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AN AREA OF UNCERTAINTY: PRACTITIONERS' EXPERIENCES WORKING WITH PSYCHOPATHY

ERIN MARIE VIGNALI

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School of Psychology

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Abstract

Psychopathy is an area of research that has been impacted by a great deal of prejudice and stigma. Studies pertaining to therapeutic interventions for psychopathy often argue that the condition might be untreatable. However, more recent research suggests that certain approaches are helpful as they work with strengths, weaknesses, limitations and self-interests. Moreover, qualitative research into both client and practitioner experience in treatment seems to be substantially lacking. The above conflicting opinions, combined with a lack of qualitative research in the area, motivated this research, which comprises an examination of the experience of practitioners who work with psychopathy. Six semi-structured interviews were conducted and analysed using Interpretative Phenomenological Analysis (IPA), which revealed four superordinate themes: "There's Something Powerful about that Label", The "Continuum", An "Area of Uncertainty, Pessimism and Nihilism" and Beyond "Hanging in There". Each theme revealed three subordinate themes related to opinions concerning the associations and characteristics of psychopathy, while lending insight to treatment approaches. The findings showed the influence that the label could have on practitioners and clients alike, with positive and negative reactions being observed. There also seemed to be the view that psychopathy, much like other mental health diagnoses, comprised a spectrum. Treatment approaches and outcomes appeared to be met with uncertainty and pessimism, with many participants sharing the difficulty of working with psychopathy. Nonetheless, effective approaches from experience were openly shared and discussed.

Keywords: Psychopathy, forensic psychology, counselling psychology, mental health, therapeutic relationship, treatment, interventions

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Accompanying Materials

USB: Containing Full Interview Transcripts (Attached)

List of Abbreviations

APA	American Psychiatric Association
ASPD	Antisocial personality disorder
BPS	British Psychological Society
DA	Discourse Analysis
DSM	The Diagnostic and Statistical Manual of Mental Disorders
DT	The Dark Triad
EPA	Elemental Psychopathy Assessment
FFM	Five Factor Model of Personality
IPA	Interpretative Phenomenological Analysis
NA	Narrative Analysis
PCL	Psychopathy Checklist
PCL-R	Psychopathy Checklist Revised
PEN	The PEN (Psychoticism, Extraversion, Neuroticism) Model of Personality
PPI-R	Psychopathy Personality Inventory-Revised
TriPM	The Triarchic Personality Measure

List of Definitions

Psychopathy Checklist-Revised (Hare, 2003)

20 Items

- Glib and superficial charm
- Grandiose estimation of self
- Need for stimulation
- Pathological lying
- Cunning and manipulativeness
- Lack of remorse or guilt
- Shallow affect or superficial emotional responsiveness
- Callousness and lack of empathy
- Parasitic lifestyle
- Poor behavioral controls
- Sexual promiscuity
- Early behavior problems
- Lack of realistic long-term goals
- Impulsivity
- Irresponsibility
- Failure to accept responsibility for own actions
- Many short-term marital relationships
- Juvenile delinquency
- Revocation of conditional release
- Criminal versatility

Two Factors:

- *Factor 1:* Interpersonal element; selfish, callous and remorseless use of others, correlated with narcissistic personality disorder
- *Factor 2:* Behavioural element; chronically unstable, antisocial and socially deviant lifestyle, ccorrelated with antisocial and borderline personality disorder

Scoring:

- Maximum score: 40
- Score from 0 to 2 on each item
- Cut off score varies dependent on country
- Score in United Kingdom is 25

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Chapter 1: Introduction, Literature Review and Rationale

This chapter comprises an overview of the current literature in the field of psychopathy. Beginning with the origins of the diagnoses in the mid-20th century, this literature review constitutes an exploration of how psychopathy has been defined, measured, assessed and treated. The chapter concludes with a rationale for undertaking this particular study, namely investigating practitioners' experiences in treating psychopathy, which could have important implications for the field.

Introduction

In the 1800s, French physician Phillipe Pinel suggested that individuals might exist in society who, independently of any delusions or psychosis caused by mental health conditions, may be able to engage in deviant behaviour. Likened to the modern day conceptualisation of psychopathy, Pinel called these individuals *manie sans delire* (mania without delirium) (Cleckley, 1941). Over a century later, the concept of psychopathy was introduced into mainstream psychiatry and psychology by American psychiatrist Hervey M. Cleckley. In his 1941 book, *The Mask of Sanity,* Cleckley described the traditional idea of a psychopath as an individual so devoid of morals that callousness, a lack of empathy and an arrogant interpersonal style led to purposefully destructive or violent acts against themselves and others. Cleckley believed that these individuals could mask these traits and behaviours so well that they could blend into society and become almost unrecognisable due to their "mask of sanity". The usefulness of this model is still apparent today as the gold standard for measuring psychopathy, the Psychopathy Checklist-Revised (PCL-R) (Hare, 2003). This assessment tool combined Cleckley's characteristics (or traits) with behaviours associated with antisocial personality disorder (Robins, 1966), such as social deviance, sensation seeking,

impulsivity, poor behavioural control, unstable, an antisocial lifestyle and proneness to boredom.

The accounts that Cleckley (1941) gathered were based on clinical interviews with men in secure institutions and, similarly, Hare's (2003) measurements were largely based on his work within secure institutions such as prisons. Given the early beginnings of the definition, as well as the characteristics that were observed, it might be no surprise that research across the field of psychology today has found a substantial correlation between psychopathy and crime (Kiehl & Hoffman, 2011). Studies have shown that those exhibiting these traits and behaviours are more likely to engage in violent crime, and are less likely to desist from crime and more likely to re-offend violently (Theodorakis, 2013; Woodworth & Porter, 2002). Moreover, in recent research it has been found that those exhibiting psychopathic traits and behaviours account for 25% of the prison population, but only 1% of the global population (Silver, Mulvey, & Monahan, 1999).

Given the substantial correlation and the presumed risk to the individual and the public, many researchers have advocated for the exploration of treatment for psychopathy, with Salekin, Worley and Grimes (2010) encouraging research into interventions that specifically target psychopathy. However, although it has been argued that there is some effectiveness in certain approaches, such as working with the client's individual and unique self-interest, strengths, weaknesses and limitations, researchers have argued that these approaches might be largely inadequate and that there is still a need for further research and understanding (Durbeej, Alm, & Gumpert, 2014; Tew, Bennett, & Dixon, 2016; Salekin, 2002).

Furthermore, although the therapeutic relationship has been shown to be important to treatment outcomes in psychopathy, there appears to be a gap in the research in terms of discussing how best to build these relationships and how to tolerate

the difficulties in doing so (Polaschek & Ross, 2010). In psychological interventions, especially those practised within the discipline of counselling psychology, a collaborative, non-judgemental, and empathic therapeutic relationship is at the core of a strong therapeutic approach (Woolfe, Strawbridge, Douglas, & Dryden, 2010; Cooper, 2008). However, despite advocating for further research into interventions, minimal research seems to have been conducted on this subject, especially that using qualitative methods to explore both client and practitioner perspectives.

The current researcher recognises that this study might not be able to fully close the gaps in literature regarding psychopathy treatment. The aim, however, is to gain an understanding of and determine the meaning in the experience and perceptions of practitioners working with psychopathy while focusing on the interactional qualities present (Eatough & Smith, 2006). Thus, the research question is: what are practitioners' experiences and perceptions in working with psychopathy, particularly with respect to the interactional qualities of the therapeutic relationship and the treatment approach? The aim of this research question is to grasp the individual experience and perceptions of each participant and to add information to the literature on *how* treatment has worked rather than *whether* or not it has worked for their clients. This could have important implications in the field, adding to the literature on treating psychopathy and promoting rehabilitation for the safety of the public and for the benefit of the individual (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007; Sampson & Laub, 1993; Olver, Lewis, & Wong, 2011).

Literature Review

Defining Psychopathy

Over the years, psychopathy has been viewed as a set of personality traits, the defining characteristics of a person's nature and behaviours. The definition, based on

personality traits and behavioural aspects, can trace its origins back to the use of the word “psychopath” in Hervey M. Cleckley’s (1941) book, *The Mask of Sanity*. The author depicted what appeared to be a concerning picture of a person so void of affect that he or she was able to commit offences, all the while wearing a “mask of sanity”. Since that time, there seems to have been a substantial amount of discourse around the term, with some believing that psychopathy was a combination of personality traits and others believing that it was defined by behaviour. Cleckley (1941) himself identified these individuals by their traits or, as he labelled them, symptoms. He listed 16 different items that he felt represented “interpersonal, affective and behavioural aspects of the disorder” (Salekin, Worley, & Grimes, 2010). According to Cleckley (1941), these symptoms resulted in superficial charm, a lack of guilt and remorse, poor insight and shallow emotional affect, as well as an insincere and manipulative stance in interactions with others, a remorselessness use of others, and a social and emotional void.

In the same year, Karpman (1941) moved away from personality traits and emphasised two distinct features of psychopathy; what he called “primary” and “secondary”. He described primary psychopathy as being characterised by “intrinsic, idiopathic deficits” relevant to the individual and likened to genetics (Andersen & Kiehl, 2014). Karpman (1941) claimed that these characteristics led the person to be selfish, calculating, indifferent, calm and untreatable. He described secondary psychopathy as being characterised by indirect factors or experiences (Daly & Polaschek, 2014). The latter included the possibility of underlying depression or anxiety, impulsivity, a quick temper, a lack of guilt and empathy but, in contrast to primary attributes, an amenability to treatment (Andersen & Kiehl, 2014; Daly & Polaschek, 2014). Karpman (1941) argued that these traits led these individuals to lie, cheat and swindle with no sense of responsibility, guilt, or even an ability to learn from their mistakes. This definition prevailed until Robins (1966) and Cloninger (1978)

expanded Karpman's (1941) theory, measuring psychopathy by behavioural characteristics such as pathological lying, use of aliases, somatic complaints, suicide attempts, drug usage and alcohol abuse problems, some of which can now be found in the DSM-5 under "Antisocial Personality Disorder" (ASPD) (American Psychiatric Association, 2013).

In 1998, Lilienfeld again moved the focus of psychopathy to personality traits, as Cleckley had done. However, this theory did not seem to stand on it's own for very long. In 2003, Hare offered an integrated theory that consisted of two sets of factors: Cleckley's (1941) personality model and Robin's (1966) antisocial behaviour model. This integrated theory constituted a holistic view of the traits and behaviours of psychopathy, boosted by its reliability and validity. Today, Hare's (2003) two-factor, four-facet model, the PCL-R, is the basis on which psychopathy is most commonly measured (Hare, Clark, Grann, & Thornton, 2000; Pereira, Huband, & Duggan, 2008). Hare (2003) states that Factor 1 consists of personality traits closely related to narcissistic personality disorder, namely low empathy, stress reactions, anxiety and suicide risk, and includes traits such as remorseless use of others, callousness and selfishness. Factor 2 is closely related to ASPD and consists of behaviours such as social deviance, sensation seeking and a chronic, unstable, antisocial lifestyle. As Hare's model (2003) allows for Factor scores to be rated from 0 to 2 depending on strength, it has been argued that the PCL-R can represent a distinct group of individuals whose characteristics and traits may range along a spectrum (Skeem, Poythress, Edens, Lilienfeld & Cale, 2003).

Given the focus on psychopathy as a conceptualisation of personality, the model of personality called "The Dark Triad" (DT) should be mentioned. This model is made up of three personality traits: narcissism, psychopathy and Machiavellianism, and is said to be correlated with a malignant interpersonal nature, exposing what is believed to

be the dark side of nature (Watts, Waldman, Smith, Poore, & Lilienfeld, 2017). These traits appear to overlap with PCL-R constructs such as being self-centred, deceitful, antagonistic and having a dominant interpersonal style (Paulhus &Williams, 2002), as well as risky sexual behaviour, difficulties in moral judgement, interpersonal difficulties, aggression, delinquency and counterproductive behaviour in the workplace (Jonason, Luevano, & Adams, 2012; Arvan, 2013; Muris et al., 2017; O'Boyle, Forsyth, Banks, & McDaniel, 2012).

However, there has been much debate around the conceptualisation of psychopathy within the DT and that this could have an impact on its usefulness within the field (Watts, Waldman, Smith, Poore, & Lilienfeld, 2017). Other researchers have asserted that the DT is largely homogeneous and one-dimensional (Jonason, Lie & Buss, 2010), which has sparked debate, because the constructs have been shown to be diverse, heterogeneous and complex, similar to the PCL-R's conceptualisation of psychopathy (Lilienfeld, Watts, Smith, Berg & Latzman, 2015; Hare, 2003). Thus, it has been concluded that the traits present in the psychopathy construct can offer no further information than that of a comprehensive psychopathy assessment (Glenn & Sellbom, 2015). Thus, despite psychopathy's close relation to personality theory, there seems to be little backing for measuring it as a construct of this personality model.

Returning to conceptualisations of psychopathy, any condition that might impact or be characterised by mental health has typically required the use of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (APA, 2013). However, psychopathy's presence, or lack thereof, in the manual has sparked some debate over the years. Since the publication of DSM-III in 1980, there seems to have been recurrent criticism that the DSM has failed to match the conceptualisations of both Cleckley (1941) and the PCL-R (Hare, 1980; 2003) models, because no recent versions have explicitly stated that psychopathy is a disorder in its own right (Crego & Widiger, 2015).

Moreover, the DSM in general has met with much criticism with respect to how criteria for disorders are decided. More specifically, the DSM I and II both received widespread criticism because diagnostic criteria were shown to be based on clinicians' perspectives of certain disorders, without any structured assessments. Additionally, in both versions of the DSM, psychopathy seemed to be aligned with antisocial traits. For example, in the DSM-I in 1952, a "sociopathic personality disturbance" was mentioned, which included an "antisocial reaction" that was said to define a "constitutional psychopathic state" and "psychopathic personality". The reaction was characterised by antisocial behaviour, callousness, and hedonism (APA, 1952). In the DSM-II in 1968 an "antisocial personality" was described and likened to Cleckley's model, characterised by callous, selfish, impulsive behaviour marked by a lack of guilt that brought the subject into conflict with society. However, there was no mention of "psychopathy or psychopathic" terminology (APA, 1968).

Then, in the DSM-III in 1980, psychopathy was again not explicitly named and could be found only in part within ASPD, which was based on Robins (1966) "sociopathic" personality (APA, 1980). During the same year (1980), Hare first developed the Psychopathy Checklist (PCL), which included a 22-item list, which was an expansion of Cleckley's original 16-item list. However, significant gaps remained between the PCL and the DSM-III. More specifically, the DSM-III required the presence of conduct disorder to qualify for ASPD, whereas the PCL did not require this for psychopathy, which created a difficulty in attempting to measure psychopathy through the DSM's ASPD. Furthermore, it was argued that the focus of the PCL seemed to be on traits, whereas the DSM's focus was on behaviour. Shortly after the original publication of the DSM-III, the version was revised and characteristics of psychopathy, such as a lack of remorse, impulsivity and failure to plan, were added to the ASPD definition. However, the DSM-III and DSM-III-R have been criticised for using a task

force that voted on adding certain diagnostic criteria and definitions to the manuals without, as Davies argues, any substantial scientific backing (Davies, 2017).

By the time the DSM-IV had been published in 1994, the PCL had been revised to its current state as the PCL-R, with the two factors mentioned above, in which Factor 1 is closely related to narcissistic personality disorder and Factor 2 to ASPD (APA, 1994; Hare, 1991). However, psychopathy was still absent in the manual and the ASPD characteristics seemed to align more closely to Factor 2 models of psychopathy, which covered mainly behaviour (i.e.: impulsivity, behavioural control and proneness to boredom) (APA, 1994; Hare, 2003). At this time, it was argued by Hare (2003) that the DSM covered only what was called the "social deviance component" of the disorder or Factor 2, but largely missed the personality component covered by the PCL-R, compromising its use as a diagnostic tool (Hare, 2003).

Finally, in the most recent DSM-5 published in 2013, there seemed to be greater acknowledgement of psychopathy, apparently driven by the influx of research on the disorder (Crego & Widiger, 2014). However, instead of following the well-established PCL-R, the APA instead decided to follow the Triarchic Model of Psychopathy (TriPM). This model is made up of three constructs: disinhibition, which includes problems with impulse control, boldness, which is closely tied to social dominance and resilience, and meanness, which is defined by aggressive behaviour without consideration of others (Patrick, Fowles & Krueger, 2009). Using this DSM-5 model is problematic because the factor "boldness" is not apparent in the most widely used PCL-R. However, the factor was strongly correlated with psychopathy in a recent meta-analysis, perhaps lending support to the DSM's conceptualisation (Lilienfeld et al., 2016).

Moreover, Strickland, Drislane, Lucy, Krueger and Patrick (2013) set out to establish whether or not psychopathy could be measured through the Personality

Inventory of the DSM-5 (PID-5). The findings indicated that facets such as impulsive externalisation and callous aggression were present in the PID-5 and that the boldness facet could also be captured using additional PID-5 traits. The researchers concluded this to mean that the PID-5 could provide adequate coverage of psychopathy.

Moreover, there seem to be many measurements other than those in the DSM. As mentioned previously, Hare's Psychopathy Checklist-Revised seems to act as the gold standard of measures, given its dominance in most of the literature. Hare (2003) uses semi-structured interviews, and information from third parties in the form of files or information related to personality traits and behaviour to measure psychopathy (Hare, 2003). Additionally, this tool has been adapted for adolescents in the Psychopath Checklist – Youth Version.

Despite the PCL-R's dominance, it is relevant to mention that other diagnostic self-report tools are available. Cooke and Michie (2001) offer an alternative to the PCL-R with their three-factor model, wherein Factor 1 is a deceitful and arrogant interpersonal style, Factor 2 a deficient affective experience, and Factor 3 irresponsible and impulsive behaviour. Cooke and Michie (2001) removed the PCL-R items associated with antisocial personality disorder in this model, because they saw this as a result of psychopathic traits and behaviours rather than a feature of the diagnosis.

A more recent model, the previously mentioned TriPM, combines both Hare's (2003) PCL-R, Cleckley's (1941) traits, as well as the PPI-R (Lilienfeld & Widows, 2005). As noted above, in terms of this model, three factors constitute psychopathy. Several other well validated self-report tools for use in both criminal and non-criminal samples include the Psychopathy Personality Inventory-Revised (PPI-R), Self-Report Psychopathy measure and the Levenson Self-Report Psychopathy Scale (Lilienfeld & Widows, 2005; Paulhus, Hemphill, & Hare, 2012).

Additionally, it has been proposed that the Five Factor Model of Personality (FFM) might also be a reliable means of measuring psychopathy. The Elemental Psychopathy Assessment (EPA) was constructed as a development of the FFM and has been shown to have both internal consistency and validity (Lynam, Gaughan, Miller, Miller, Drew, Mullins-Sweatt, & Widiger (2011).

Although there are multiple models to measure psychopathy, those that measure change in psychopathic traits over time seem to be lacking. As this area is arguably important for measuring treatment response (Craig, Dixon, & Gannon, 2013), Cooke et al., (2004) developed the Comprehensive Assessment of Psychopathic Personality (CAPP). This tool is a semi-structured interview that measures psychopathy based on six domains: the self, emotional, behavioural, attachment, cognitive and dominance, which all contain several symptoms. CAPP evaluates these traits, independently of criminal behaviour. Although it was thought for many years that the tool was in need of further refinement (Craig, Dixon, & Gannon, 2013), a recent study by Flórez et al., (2018) showed the CAPP to be a robust way of evaluating change in psychopathy within a forensic setting.

Psychopathy and Crime

As evidenced by the research above, there is a considerable amount of debate in the field of psychopathy. Researchers have had differing opinions as to how to define the traits and behaviours that characterise the condition, how to measure these traits and, even, how to refer to someone with psychopathy. Researchers Kiehl and Hoffman (2011) argue that, within the legal system, the term “psychopath” has been inappropriately used as a “synonym for incorrigible” and that this worrying parallel creates false perceptions. This attitude toward the term can similarly be seen in popular media. Take, for example, Patrick Bateman in the film *American Psycho* or Alex from *A*

Clockwork Orange. Skeem, Polaschek, Patrick and Lilienfeld (2011) argue that judgements such as these lead to negative associations in psychopathy, both in the general public and in research.

The consequences of the assumptions about psychopathy are difficult to determine in certain contexts. Although Skeem et. al (2011) argue that myths associating these individuals with violence will encourage faulty assumptions about "violence risk", there is little evidence to suggest that diagnostic labels affect verdicts (Filone, Strohmaier, Murphy, & DeMatteo, 2013), even to the extent that those exhibiting psychopathic traits and behaviour are 2.5 times more likely to be granted conditional release than undiagnosed individuals (Porter, Brinke, & Wilson, 2009). The researchers point out the "alarming" possibility that these individuals' skills of manipulation cannot only work to sway decision makers but also help to perpetuate an appearance of rehabilitation (Porter, Brinke, & Wilson, 2009).

More specifically, when considering the link between psychopathy and crime, Theodorakis (2013) found in a meta-analysis that for those with low, medium and high PCL-R scores, the percentages of reoffending were 39.7, 54.9 and 74.1 respectively, suggesting a strong correlation between the degree of psychopathy and likelihood of desistance from crime. Furthermore, in an examination of 125 convicted homicide prisoners, those exhibiting psychopathic traits and behaviours were found to be 93.3 times more likely to commit premeditated murder in comparison to just 43.4 for the general prison population (Woodworth & Porter, 2002).

Although there appears to be evidence to suggest this link there lies a complication with this association with violence. Todd, Wade, and Renoux (2004) assert that perpetrators of violence use distinct language to depict an offence or instance. They argue this language may imply power, isolating and threatening the victim, whilst trying to control their own appearance and to avoid taking responsibility.

Further to this, Coates and Wade (2004) revealed in their study that judges may inadvertently play into this lack of responsibility by using pathology, trauma, personality traits, impulsivity, and a difficult upbringing in their verdicts and sentencing. Thus, this may feed into a particular narrative which takes away responsibility from the perpetrator. In the instance of those perpetrators with psychopathy, it may be that their own backgrounds, traits, or diagnoses may be used in their own sentencing which may take away from the individual's ability to assuming responsibility for their criminality. Moreover, a focus on pathology, and in the case psychopathy, may again reduce the perpetrator to their diagnoses which may oversimplify the factors at play in the violence.

Again, reducing the cause of violence to that of psychopathy may be oversimplifying a complex issue as some authors have argue that there could be other factors at play. Firstly, in 2003, Blackburn, Logan, Donnelly and Renwick found that psychopathy had a prevalence rate of 23% among prisoners with mental health disorders. Comorbidity has been shown with antisocial personality disorder, and histrionic, narcissistic and borderline disorder personality disorders (Nioche, Pham, Ducro, de Beaurepaire, Chudzik, Courtois, & Réveillère, 2010), as well as a strong positive correlation with substance abuse (Stâlenheim & von Knorring, 1996).

Moreover, there appears to be a number of personality traits that, on their own, have shown a correlation with the antisocial behaviour present in psychopathy. As early as 1977, Eysenck correlated his PEN model (Psychoticism, Extraversion, Neuroticism) to antisocial behaviour and was supported in his theory by Cloninger, Svrakic and Przybeck (1993). These particular traits can often predict criminal behaviour, institutional misconduct and recidivism in individuals with or without psychopathic traits and behaviours (Gardner, Boccacini, Bitting, & Edens, 2015).

In a broader sense, the literature around personality and criminality has been a persistent debate, with some arguing that personality factors alone cannot predict criminality (Rean, 2018). These theorists argue that personality traits that are seen in those who commit crimes are often seen in those who do not and therefore cannot be seen as the source of their criminality. Other theorists argue that criminality is situational and that it is rather dependent on what is happening in a person's life. A more integrative model suggests, alternately, that there might be interplay between situational factors and personality factors. Based on this, theorists suggest that the personality factors determine behaviour while situational factors act as moderators (Rean, 2018).

Treatment for Psychopathy

In contrast to the overwhelming amount of research that can be found to define and measure psychopathy, research into finding treatments that are tailored to the needs of the individual seem to be lacking. As some researchers have argued, it seems as though these weaknesses in the field of psychopathy may have to do with the myths around the condition and a general "therapeutic pessimism" (Salekin, 2002; Sörman et al., 2014), which Salekin (2002) argues has led to inappropriate interventions and a lack of research in this area.

When considering therapeutic interventions, it might be appropriate to begin with the therapeutic relationship, because this alliance between the client and the practitioner has been shown to be relevant to treatment outcomes. In psychology, it has been argued to be the tool by which the therapist is able to adjust his or her practice to the client (Kazantzis, Dattilio, & MacEwan, 2005). Moreover, a strong therapeutic relationship grounded in acceptance, empathy and positive regard has been shown to have a positive effect on the client's progress (Woolfe, Strawbridge, Douglas, &

Dryden, 2010; Castonguay, Beutler, 2006; Norcross & Lambert, 2011). However, those with psychopathy and personality disorders seem to struggle with interpersonal relationships. More specifically, Williams and Simms (2016) found that the facets of extraversion, hostility (neuroticism) and negative affect present in psychopathy often negatively affect the establishment of strong interpersonal relationships (Ullrich & Coid, 2011). More specifically, those with high Factor 1 scores on the PCL-R might struggle to form attachments, which can impact treatment outcomes (Martin, Garske, & Davis, 2000). However, despite the importance of the relationship and the acknowledgement of the difficulty in building it, there seems to be a lack of research giving practitioners strategies to develop this.

Moreover, the notion that psychopathy might be untreatable or that treatment could make those with psychopathy worse appears to be a persistent theory in the field. One particular study conducted by Dr. Elliot Barker in 1968 suggested that psychotherapy did this by increasing the likelihood of a violent relapse (Barker, 1968 as seen in Malatesti & McMillan, 2010). Barker's study has been widely quoted in the literature to support the notion that psychopathy is untreatable. However, on closer analysis of the study, it was found that the intervention included confining nude participants together for two weeks in a windowless room. They were then fed through tubes in the wall and were given lysergic acid diethylamide (LSD; Barker, 1968 as seen in Malatesti & McMillan, 2010). It was believed at the time that this could help the clients break down their defences. Those with psychopathy were seen to have rigid defences and the researchers maintained the belief that the LSD could help to disrupt these defences (Skeem, Douglas, & Lilienfeld, 2009). Even further exploration into the untreatibility of psychopathy was conducted by D'Silva, Duggan and McCarthy (2004) in a review of 24 treatment studies; the researchers found that there was a significant lack of evidence in studies that supported the adverse effects of therapy. Furthermore,

most recently, Craig, Dixon, and Gannon (2013) argued that the *right* kind of treatment for psychopathy should to be found because, as Wong and Hare (2009) pointed out, the *wrong* treatment could be the reason for which those with psychopathy worsen.

There has continued to be significant criticism of research that depicts psychopathy as untreatable. Although those with the condition might respond less well to treatment than those without psychopathy, this does not mean that they did not benefit from treatment at all (Garrido, Esteban & Molero, 1996; Salekin, 2002). Historically, it has been shown that there have been low to moderate effects of therapy on psychopathy (Salekin, Worley, & Grimes, 2010), but researchers have argued that although the personality traits found in psychopathy might be difficult to change, their antisocial behaviours might be treatable (Craig, Dixon, and Gannon, 2013). Thus, if treatment is focused on these factors of psychopathy, it might impact treatment outcomes.

However, researchers have argued that psychopathy is comprised of a heterogeneous population and that, in order to consider appropriate treatment, individuality should be considered. This group appears to have a variety of behaviour and trait combinations, combined with their own individual differences that should be taken into account (Craig, Dixon, and Gannon, 2013). Further to this, Skeem, Monahan and Mulvey (2002) found that, after controlling for confounds, psychopathy alone did not predict poor treatment outcomes.

Moreover, with specific reference to the PCL-R, its spectrum-type nature enables individuals to score high, moderate, or low on the assessment. This has proved to be significant in considering treatment. Thornton and Blud (2007) found that those who scored higher on the PCL-R had typically not responded to treatment as well as those who scored lower. More specifically, it has been found that outcomes might vary within the population. Researchers have found that even within a factor, different traits

might respond differently to treatment than others. For example, individuals who have traits of grandiosity within Factor 1 might seek status and thus respond aggressively to possible challenges to this status (Hemphill and Hart, 2002; Hobson, Shine, and Roberts, 2000). Additionally, researchers have suggested that these individuals might also see little reason to change and might also be more adept at manipulating others, showing themselves in a positive light by making it difficult to gather factual accounts of their mind-set (Thornton & Blud, 2007).

In further support of considering the diversity of the population, researchers have also suggested that finding an individual's motivation for change, based on their PCL-R profiles, can positively influence treatment outcomes. For example, practitioners working with individuals interested in status, like those above, might depict committing offences as low status and thus create a motivation for change. Moreover, individuals who exhibit a need for control might benefit from treatments that allow them choices and promote their taking responsibility for their actions (Harris, Attrill, and Bush, 2005). Wong and Hare (2009) suggested that those who score high on Factor 1 might have many of the skills needed for treatment but that motivation is at the core of producing a positive outcome. They suggest that building a working alliance characterised by professionalism and respect that is aimed at working collaboratively to achieve tasks rather than focusing on feelings might be helpful, because those who score high tend to view affect as a sign of weakness.

Furthermore, Hobson, Shine and Roberts (2000) found that individuals whose traits load on Factor 2 might pose difficulties in therapeutic communities because they often engage in disruptive behaviour. Similarly, Thornton and Blud (2007) indicate that their likelihood of getting bored and acting impulsively could lead to their breaking rules and pushing boundaries. It is also thought that they might find it harder to remain in treatment, as well as achieve goals and complete tasks.

Craig, Dixon and Gannon (2013) suggest that finding a client's strengths when working with psychopathy could be key to positive treatment outcomes. They argue that this could provide an opportunity for positive reinforcement. This idea is also present in the current literature as a method to increase desistence and it has been argued that psychopathy should not be an exception to this (Linley and Joseph, 2004; Craig, Dixon, and Gannon, 2013).

Researchers have also suggested that working with the limitations of those with psychopathy is important. Thornton and Blud (2007) suggest that, for those who score high on the affective items of Factor 1, it might not be helpful to try to challenge their clients in order to increase their empathy. Instead, it has been suggested that these types of interventions could actually aid individuals to appear as though they understand empathy when they do not. However, those who score lower on these same items might respond well to this type of treatment. This indicates that the PCL-R can be an effective way of individualising treatment for this heterogeneous group.

The Chromis Programme, which was specifically designed for treating psychopathy, should also be mentioned. In 2004, the Correctional Services Accreditation Panel (CSAP) in the United Kingdom accredited the programme. It is informed by the Risk Needs Responsivity principles that have been shown to have particular relevance to working therapeutically with those who have committed crimes. The programme is currently run as part of the Dangerous and Severe Personality Disorder (DSPD) units at HMP Frankland, HMP Low Newton and HMP New Hall. It is said to address the risk of violence and has demonstrated some effectiveness (Craig, Dixon, and Gannon, 2013; Tew, Bennett, and Dixon, 2015).

Thus it appears there is no single modality or intervention present in the literature today that has been found to be effective. Instead, researchers tend to argue that individual factors on the PCL-R or other measures of psychopathy should be

considered. This individuality, in turn, might inform the treatment approach, in terms of an individual's self interest, motivation, strengths, weaknesses and limitations.

However, although there is research in the field that provides valuable insight into how to treat psychopathy, there appears to be a number of areas that require improvement. Most of the research surrounding individuals who exhibit traits and behaviours of psychopathy is focused on those who commit crimes when, in fact, many of these individuals are living what could be seen as normal lives within the community (Listwan, Piquero, & Van Voorhis, 2010). Skeem et al. (2011) argue that this might be the most important myth to dispel. They insist that psychopathy does not go hand in hand with violence and does not predict future violence any more than a history of violence would. Broadening the field with research into those who exhibit psychopathic traits and behaviours but do not commit crimes might help to determine what is unique about these individuals.

Additionally, quantitative research into treatment for psychopathy has been questioned for its quality (Craig, Dixon, & Gannon, 2013). More specifically, in 2004 researchers reported that they were unable to conduct a meta-analysis of the treatment of psychopathy because they were unable to find a single piece of research that had appropriate control, used Hare's model (2003) to focus treatment, and had appropriate outcome variables and an adequate follow-up period. Moreover, other researchers found that many of the studies examining treatment options and their outcomes had both a lack of controls and psychometric data (Skeem, Monahan, & Mulvey, 2002; Kotler & McMahon, 2005). This can lead to difficulties in ascertaining which treatment methods are genuinely effective because there is no baseline of comparison and the data collected is one-dimensional.

Further to this, Craig, Dixon and Gannon (2013) point out that there are variations in how psychopathy is assessed, how treatment success is defined, how

intervention aims and methods are defined, what the make-up of the research sample is, how the data is defined and, finally, what statistical analysis is used. The researchers found that all these factors influenced current perceptions of psychopathy and treatment.

An additional complication in the research is found in comorbidity. It appears that much research does not take into account the issue of comorbidity with mental health disorders or substance abuse, which is prominent in psychopathy (Skeem, Monahan, & Mulvey, 2002; Davis, Sheidow, & McCart, 2015). A lack of research into this comorbidity can lead to the question of whether we can identify any one treatment to treat psychopathy.

Lastly, Craig, Dixon and Gannon (2013) shared their concern that many of the interventions that have been studied in the past are not necessarily up to date. This means that the interventions used previously were not accredited by the CSAP, which is the current standard, because it maintains good practice in both treatment design and delivery. For example, therapeutic communities in practice now appear to be quite different from those in the past, which were deemed to be unhelpful for psychopaths. Thus, more research is needed to evaluate current treatments and their impact on psychopathic traits and behaviours.

Qualitative Research in Psychopathy

When considering practitioners' experience in psychopathy, it might be important to consider client experience as a point of comparison. This means that it might be relevant to see if the opinions of the client and the opinions of the practitioner align in reference to their treatment. However, in the context of client experience in therapy, there appears to be a significant void in research. Constantino, Arnkoff, Glass, Ametrano and Smith (2011) point out that clients' experiences account for only 1.4% of the variance in meta-analysis.

In the psychopathy literature, two studies have been found that cover client experience. In the first, Durbeej, Alm and Gumpert (2014) found differences in client perceptions and needs between high and low scores on the PCL-R. Generally, the higher group was more complex to treat, with low engagement in therapy driven by a lack of willingness to change, a lack of confidence in treatment and a lack of perceived treatment need.

The participants also felt they struggled to ask for help and described having to hit "rock bottom" in order to begin the process of change. However, they felt they had been subjected to pressure to participate in treatment. The researchers found that context was important in both groups: that poor physical treatment, prejudice, a sense of inferiority, a lack of activities and a focus on medication was seen as problematic to the participants. Moreover, the latter stressed the importance of tailoring therapy to their individual needs, having long-term therapy and the therapeutic alliance as essential factors.

In the second study, Tew, Bennett and Dixon (2016) found, as mentioned in previous studies, that client motivation was an important factor in determining change. Additionally, the clients in this study acknowledged that forming relationships with staff and feeling comfortable in their environment were also important factors. Additionally, they found that those with Factor 2 characteristics on the PCL-R exhibited the most change (i.e.: impulsivity, behavioural control and proneness to boredom).

Both studies seem to have found that therapy helped the participants to re-integrate into society and increased their confidence. The participants advocated for an individualised type of treatment, characterised by respect, which steered away from the medical model, and helped them to make and sustain attachments to those around them.

Despite the few studies on client experience, there seems to be an even larger gap in research into practitioner experience in working with psychopathy. A search of

the current literature did not yield any results concerning practitioner experience in qualitative or quantitative studies. It must be said that Dr. Matt DeLisi (2016), the author of *Psychopathy as a Unified Theory of Crime*, referenced his own experience as a practitioner in his work and there have been several news articles with anecdotal evidence from practitioners commenting on the nature and treatment of psychopathy. However, DeLisi's experience, as well as that of the other professionals, does not appear to have been qualitatively or quantitatively analysed in an independent study. Thus, there has not been any opportunity to source analysed experience to lend support to or spark debate around current theories of how to approach working with psychopathy.

Rationale

It is argued that qualitative research provides insight into an issue or helps one to develop new ideas. Thus, within the current study, investigating practitioner experience might reveal some of the underlying opinions, motivations and origins of the therapeutic approaches to psychopathy (Willig, 2013).

The studies appraised in this literature review indicated that the therapeutic relationship was significant for treatment outcomes in psychopathy (Polaschek & Ross, 2010). Research has suggested that specific therapeutic models have less impact than a strong therapeutic relationship; thus the establishment of an appropriate rapport remains imperative (Cooper, 2008). More specifically, studies have shown that a strong therapeutic alliance can positively impact treatment outcomes and, moreover, that the relationship itself is important to clients with psychopathy (Polaschek & Ross, 2010; Durbeej, Alm, & Gumpert, 2014; Tew, Bennett, & Dixon, 2016). However, there seem to be significant difficulties in building these relationships, especially considering the interpersonal struggle those individuals with psychopathy experience (Williams and

Simms, 2016). Moreover, research into how practitioners can build these relationships with such complex presentations seems to be sparse. In the current study, investigating the subjective interactional qualities of the therapeutic relationships of the participants could have important implications for this area of psychopathy.

Additionally, research honouring not only the subjectivity of this relationship but also the importance of it might be relevant to the field of counselling psychology. The field promotes an increasing awareness of this relationship in the field of psychology (Woolfe, Strawbridge, Douglas, & Dryden, 2010; Cooper, 2008). The discipline holds the therapeutic relationship as not only vital but fundamental to working therapeutically with individuals. In the field, a collaborative, non-judgemental and empathic therapeutic relationship is considered to be at the core of a strong therapeutic approach (Woolfe, Strawbridge, Douglas, & Dryden, 2010; Cooper, 2008). Thus, investigating the presence of these elements and others within practitioner experiences might have important implications for the field.

Also apparent in the literature review was the difficulty in establishing treatment approaches for psychopathy (Salekin, 2002). From the literature, it appears that the idea that psychopathy might be untreatable persists when, in reality, it seems it may be difficult to treat but not impossible (Garrido, Esteban & Molero, 1996; Salekin, 2002). The literature suggests that an individualised approach, taking into account a client's motivations, strengths and weaknesses, might be integral to the work but there does not appear to be qualitative research to support these claims (Craig, Dixon, & Gannon, 2013). This might be considered a weakness, because qualitative research into these types of approaches could help to add further depth to these claims and possibly add further research to the area (Willig, 2013).

Moreover, this individualised approach, if seen in the current study, may be particularly relevant to counselling psychology, which, as a field, promotes respect for a

client's subjective experience (Woolfe, Strawbridge, Douglas, & Dryden, 2010). In honouring this subjectivity, the discipline recognises that an idiographic approach to therapy might be crucial, while acknowledging that each client comes with an individual set of needs and experiences (Woolfe, Strawbridge, Douglas, & Dryden, 2010).

Additionally, the profession recognises that practitioners learn from reflecting on their own experiences in practice. Thus it might be helpful for other professionals to examine the insights of their colleagues, as presented, in this research, and improve their own practices (Schön, 1983). As evidence-based practice is fundamental to counselling psychology, being able to demonstrate expertise in a given area is imperative to justifying an approach; thus the current study might help practitioners to find a basis upon which to build their practices.

Thus, the current study, by asking the participants what their experience treating psychopathy has been may be relevant. The research question investigates the interactional qualities and treatment approaches of practitioners which might add to the literature on how practitioners might adapt their approach to the unique needs of their clients. This information could have important implications for the fields of both psychopathy and counselling psychology.

Methodology

In this chapter the conceptual and epistemological foundation of this research and how it impacted the choice of analysis is outlined. To guide an understanding of how the research was conducted, the research design, information about the participants and how they were recruited are detailed, as well as the specific steps taken in the analysis stage.

Research Design

This study is a qualitative research study in which Interpretative Phenomenological Analysis (IPA) is utilised. This method was used to analyse six semi-structured interviews with practitioners from various psychological professions. The interviews covered their experience in working with psychopathic clients.

Conceptual and Epistemological Issues

Many health practitioners today are trained to view mental distress as a phenomenon that is individualised or idiographic (Harper & Thompson, 2012). Similarly, counselling psychologists adopt this approach and draw from a number of disciplines to interpret their client's distress (Woolfe, Strawbridge, Douglas & Dryden, 2010). The discipline recognises that both nature and nurture or, more specifically, society, culture and biology, serve a function in this distress and thus effect behaviour, affect and experience (Harper & Thompson, 2012; Woolf, Strawbridge, Douglas, & Dryden, 2010). Counselling psychologists are thus encouraged to take the same approach to their research, using this perspective to collect data and make sense of their participants' experience in order to create a rich evidence base from which to practice and research (Woolf, Strawbridge, Douglas, & Dryden, 2010).

In the latter case, it can be argued that an important first step in research is to uncover the innate epistemology, or the study of knowledge, that we feel best suits our understanding of the world. In essence, to understand how we view the world and knowledge is to understand how we should go about gaining that knowledge through our research. More specifically, Tseelon (1991) argues that our understanding is within the method we choose, because these methods take on different meanings depending on the interplay between our methodologies and epistemologies. Once discovered, our epistemology creates the stage for this by allowing researchers to show that both their epistemology and means of analyses are closely aligned (Willig, 2013). This proves to be an important step in qualitative research in particular because the researcher's awareness of epistemology enables him or her to both reflect upon and engage with the research (Harper & Thompson, 2012). Based on these assumptions, it can be argued that, as researchers, we consciously pick our methodologies but it is the interaction between our inherent epistemologies and self-reflection that allows us to uncover how our view of human nature impacted this decision.

As a trainee counselling psychologist who has typically worked with marginalised populations whose voices have often been drowned out, the approach that seemed to be most aligned to this type of work and with this researcher seemed to be to attempt to gain an understanding through context while having respect and curiosity for individual experience. Thus, this value base seemed to resonate with Roy Bhaskar's theoretical framework of critical realism (Bhaskar & Hartwig, 2010). This viewpoint is concerned with issues that relate to "culture, context and society" and is not dependent on what can be empirically observed (de Souza, 2014; Sayer, 2000). As a less naïve perspective along the realist continuum, it lends support to the belief that knowledge production has a subjective element (Willig, 2013). As Bhaskar observes, scientific experiments involve creating controlled environments in which causal mechanisms can

be observed (Bhaskar & Hartwig, 2010). It is his belief that if these mechanisms are dependent on certain conditions, then it is equally plausible to assume that mechanisms can also “exist, endure and act outside experimental conditions” and empirical observation (Bhaskar & Hartwig, 2010). It is the distinct belief of critical realists that natural and social objects have causal mechanisms, whether or not these mechanisms are currently empirically observable, and that this possibility warrants investigation into their structures and conditions (Collier, 1994). Moreover, critical realists believe that the data we collect in research can provide insight into the reality of our participants but that this is not a direct window through which we can clearly view the reality of our participants (Harper, 2012). These researchers assume that our data cannot tell us explicitly what it is that drives and maintains the rule-bound reality that we live in and this is why a level of analysis that goes beyond text and draws from theory across disciplines is needed (Harper, 2012). Arguably, this may appear to reflect the integrative approach that counselling psychologists adopt in practice (Woolfe, Strawbridge, Douglas, & Dryden, 2010).

Qualitative Research

Qualitative methods are also grounded in the philosophical underpinnings from which they are derived; thus considering one’s own philosophy is imperative. For this research, guided by the beliefs of both critical realism and counselling psychology, (Harper & Thompson, 2012), qualitative, individualised and holistic approaches appeared to suit this study best (Willig, 2013). In contrast to quantitative research, a qualitative approach is concerned with meaning and less with the cause-effect relationship (Willig, 2013). Additionally, qualitative methods are used to draw out the philosophical and sociocultural origins of certain phenomena and concepts within

society. Language, social interaction and culture are central to this type of research (Yardley, 2000).

Moreover, qualitative research allows for a level of creativity. We do not simply draw our findings from science but also from our own creativity (Willig, 2013). Willig (2013) asserts that qualitative research operates in a space wherein art and science are at one with each another. She argues that the concepts of creativity and subjectivity are not mutually exclusive in qualitative studies. This parallels both Schön's (1983) and Winnicott's (1964) ideas about being a reflexive practitioner and, as a trainee counselling psychologist, the interaction between the two seemed vital. Schön (1983) claimed that reflexive practice engaged the practitioner in "artful doing" and Winnicott (1964) talked about reflection in the transitional space as the realm of the artist, and a place of creativity and exploration.

As the participant is the central figure from which information on concepts and phenomena may be derived, in qualitative research the relationship between the researcher and the participant is central and likened to that between a client and therapist (Yardley, 2000). Although a quantitative approach might enable one to be as exploratory and empathetic as qualitative researcher aims to be, it has been argued that qualitative methods might be more suited to this (Yardley, 2000). More specifically, researchers using qualitative methods believe that the use of preconceived variables present in quantitative research would, in contrast to open-ended qualitative research, steer the participants responses in such a way that it would detract from the participants' meaning (Willig, 2013). Thus, one follows the lead of the participants, acknowledging that their environments are 'open systems' of on-going change (Willig, 2013).

However strong the relationship between the researcher and participant might be in qualitative research, the methods themselves are under a particular amount of scrutiny. Most qualitative studies that are said to be on an expert level appear to be

outside the field of psychology (Yardley, 2000). This poses a problem for qualitative methods used within the field of psychology because these researchers would typically be under the critique of professionals from other disciplines who might not understand the rationale behind the methods chosen for the research (Stern, 1997). It appears that qualitative researchers' difficulty in establishing a set of methods, assumptions and objectives for the field creates doubt and raises questions about the validity of the research findings. Thus, Yardley (2000) argues that in order to give the field credibility, a meaningful set of criteria for the methods used in qualitative research needs to be established in order to give them validity.

Despite the need for standards in qualitative research, it has also been argued that to try to find a universal way of carrying out these studies would directly conflict with the reality, truth and knowledge that the methods set out to measure, because amongst communities the idea of a universal truth would be rejected (Guba, 1992; Feldman, 1995; Greenhalgh & Taylor, 1997). Furthermore, Yardley (2000) argues that what is found in qualitative research is a communal construction and that any one standard that deems findings correct would restrict the possibilities for the researcher to interpret what is seen as one of the infinite interpretations of the data. This makes factors such as reliability and replicability impossible in this type of research, because it is largely subjective.

Although it has been argued that standards for qualitative research are impossible to set, Yardley (2000) attempted to create a model to help to manage the quality and credibility of the research. The first criterion is 'Sensitivity to Context', which, Yardley argues, means the researcher should be aware of the philosophical underpinnings of the methodology one is using, especially in phenomenology, because this provides knowledge of the perspectives within the approach, which might facilitate a more in-depth analysis. This criterion also takes into account the importance of

culture, language and social interaction. More specifically, Yardley (2000) argues that understanding the context of the research, meaning the sociocultural setting, might help the researcher to develop and acquire the meaning beneath the phenomenon that is being studied.

Yardley (2000) also promotes the importance of the researcher being aware of one's own actions and characteristics that help one to improve one's ability to interpret the meaning and function behind the data. A qualitative researcher recognises the inability to remain completely neutral during the interview process and sensitivity to these effects is paramount (Potter & Wetherell, 1995). Yardley points out that the relationship between the participant and researcher in qualitative research places participants outside the boundary of traditional "subjects" that they were once confined to in traditional research. She argues that although qualitative researchers attempt to create a more equal relationship between the interviewer and interviewee, the researcher's status as an "expert" cannot be ignored and that, as other researchers have argued, their ability to independently interpret the data should not be abandoned by considering the participants' opinions to be authoritative (Reismann, 1993).

The second criterion is "Commitment, Rigour, Transparency and Coherence". Yardley (2000) argues that commitment and rigour can be achieved through levels of analysis in which the researcher demonstrates extensive contemplation and empathic exploration of the topic being studied in conjunction with theorising. This is meant to enable one to transcend superficial understandings of a phenomenon and requires a great deal of intuition and imagination (Cooper & Stephenson, 1996).

Transparency and coherence are said to relate to both the clarity and cogency of the study. The researcher should not merely describe what has been found but rather construct a version of reality from the data (Brunner, 1991). Additionally, Yardley (2000) supports other researchers in arguing that the researcher should exercise a level

of transparency and fully detail the process of data collection and the rules used to code by presenting excerpts that are available to other researchers (Huberman & Miles, 1994; Peräkylä, 1997).

Finally, the last criterion is "Impact and Importance", which Yardley explains is the standard by which the research will be judged on its impact and utility. More specifically, Yardley (2000) assigns a piece of research importance on its ability to take empirical data and to present it as a new and challenging viewpoint that provides a new understanding of a topic. Thus, the novel aspect of the research is that it must have an impact in the academic field.

Interpretative Phenomenological Analysis (IPA)

In choosing a methodology, it was important to choose one that would enable the participants to share their experience of building therapeutic relationships as well as choosing and delivering therapeutic approaches. It was considered crucial to be able to grasp the participants' meaning behind these stories and this was kept in mind while reviewing methodologies.

Within qualitative research, there are a number of methods that facilitate engagement with creativity and subjectivity that could help to give the participants voice. When considering interviews with participants with this aim in mind, the phenomenological method seemed to be a good fit. Although phenomenology has been viewed as having its own epistemology (Willig, 2013), it has been argued that IPA is rooted in both the social cognition paradigm and in critical realism (Fiske & Taylor, 1991; Bhaskar, 1978). The critical realist perspective honours subjective experience and the features of reality that maintain them, while social cognition theory includes the notion that both human behaviour and speech can reflect this experience (Fade, 2004).

Therefore a phenomenological methodology, as a way of understanding this type of lived experience, seemed to suit the research.

In order to attempt to unearth an individual's unique experience, Fade (2004) argues that IPA is an appropriate methodology by which researchers can access the social cognition paradigm, thus uncovering the individual's experience through speech and behaviour. Phenomenology, as first formulated by Edmond Husserl, focused on the world as it presents itself to us and how we experience it in certain contexts, rather than a more general, abstract view (Willig, 2013). Expanding on this, Martin Heidegger, Husserl's student, brought in a hermeneutic version, highlighting the impact that researchers have on their studies and how this influence is a vital, integral part of IPA (Willig, 2013). Furthermore, Schmidt (2006) explained that the concept of the "hermeneutic circle" was one in which we could not understand the parts of the whole without understanding the whole and vice versa, giving a holistic approach involving both the participant and researcher.

As both Heidegger (Willig, 2003) and Schmidt (2006) emphasised, it is important in IPA to consider the roll of the researcher in what Smith, Jarman and Osborn (1999) called "the primary analytical instrument". In other words, IPA is in essence dependent on the viewpoint of the researcher (Willig, 2013) and this is a necessary tool for interpreting the data (Smith, Jarman, & Osborn, 1999). The researcher is required to attempt to take a "reflexive attitude" to his or her contribution to the research in that he or she should recognise the importance of his or her own beliefs (Willig, 2013). Although the researcher does not concretely state how these are present in the research, he or she should understand that the relationship between "old" knowledge and "new" phenomenology aids in making understanding possible (Willig, 2013).

More specifically, IPA consists of six stages of analysis, but several authors argue that there is no single prescribed method for attending to these stages and that flexibility is paramount to the methodology (Smith, Flowers, & Larkin, 2009). However, the core processes and principles should be adhered to. Reid, Flowers and Larkin (2005) state that the processes include moving content from that which is particular to the individual to that which is shared and from descriptive to interpretative. Moreover, the principles are a focus on personal meaning making, as well as understanding the participants' point of view.

Rationale for Using IPA

As the focus of the research was on *how* and not *whether* treatment works, there was a specific interest in uncovering the subjective experience of the practitioner who, in turn, also sought to gain an understanding of the subjectivity of the individuals with whom they work. Thus, methodologies suited to explore experience seemed to fit the research topic and aims.

As the aim was to gain an understanding of my participants' experiences and emotions in treating and building a therapeutic relationship with their clients, narrative analysis was considered. Narrative analysis (NA) is based on the idea that telling stories is part of a natural human impulse and that through this participants can share their identity, relationships and emotions, as well as being a means of enabling people to make sense of their own worlds (White, 1981; Bruner, 1986). However, there was some uncertainty about the epistemological influences and methods within the methodology. Yardley (2000) argues that one of the most important aspects of meeting standards of credibility for qualitative research is to understand the philosophical underpinnings (Redwood, 1999; McLeod & Balamoutsou, 2000). There was a concern that this

uncertainty could impact the credibility of the current research and thus, this method was rejected.

Discourse analysis (DA) was also reviewed. DA's strength is in viewing not what is being said but how it is being said. The methodology is considered useful when trying to understand social phenomena because it is believed that individuals' internal beliefs might differ from what they are actually communicating. Moreover, it has been argued that the methodology can enable one to uncover certain elements of culture apparent in language that indicate that certain opinions are not sincere. However, DA's strong focus on language can lead one to neglect the content of the phenomena. Although language is important because of the stigma associated with the diagnosis, the content of the experience the practitioners share is integral to building a picture of their experiences and their implications for the literature.

IPA is not without criticism, however. Although it has been used in this study to examine the usage of certain terminology, some authors have argued that it does not recognise the role of language (Willig, 2013). However, it has also been stated that because IPA takes into account the meaning derived from certain aspects of language, such as discourse, metaphors and narratives, the meaning IPA seeks to uncover is in and of itself closely connected to the language used (Willig, 2013).

IPA has also been criticised for its inability to capture true experiences and the meaning of these experiences. More specifically, it is believed by some that IPA may only gather opinions on experience, and that participants and researchers need adequate communication skills to obtain meaning. However, as a critical realist, this criticism has been acknowledged, because a premise of this epistemology is that findings uncovered using IPA do not provide direct access to experience and meaning, and only touch the surface of deeper social, psychological and discursive structures. Proponents of the methodology do not claim that one can grasp any deeper meaning; thus the terminology

in IPA provides what Willig (2013) calls a “sense of discovery rather than of construction” in the use of themes “emerging” and categories being “identified”. Moreover, when considering this criticism, it might be important to consider the current participants’ ability to communicate. As therapeutic practice requires high-quality communication skills, the participants were expected to be able to engage with a level of introspection and thus adequately express their experience and the meanings beneath them.

An additional criticism of IPA is its lack of ability to explain why a particular phenomenon occurs because its focus is on perceptions. It has been argued that if the methodology were to address meaning more accurately, the participants’ histories, past events, culture and socioeconomic factors would be considered (Willig, 2003). This is arguably a more holistic view that can be taken with participants. However, Smith, Flowers and Larkin (2009) argue that some of these factors, in particular cultural factors, are attended to through the use of hermeneutic, contextual, and idiographic analysis. Despite this, Willig (2013) emphasises that it is not the role of IPA to address the how and why a phenomena is occurring. Rather, she argues, the researcher might be able to think critically about the person’s past events, histories and social structures that might have impacted his or her experience, but that IPA itself is more concerned with gaining insight into the experiences of specific participants at certain times in their lives.

Moreover, it must be said that no research methodology is without limitations or criticisms and although it is possible address some of the criticisms of IPA one cannot address them all (Smith, Flowers and Larkin, 2009). Thus, this researcher recognises and reflects on the knowledge that not all be able to attend to all these limitations but will use the means discussed above to attempt to address these concerns.

Ethics

This research was approved by the Department of Psychology at the University of East London before recruitment and data collection began. In completing the Ethics form, the British Psychological Society's Code of Ethics and Conduct (2018) was considered. This states that confidentiality and anonymity must be upheld, that the research participants must be protected from physical or psychological harm, and that their dignity and rights must be maintained.

As there was no need to conceal the research aims, information sheets were given to the participants that explained the nature of the study, both as part of the recruitment process and before the interviews (Appendix A). This was to ensure that the participants knew the full details of the study prior to consenting to participate and to review these details prior to the interviews. If a participant agreed to take part in the study, a time and place would be determined via email. Then an invitation to participate was sent via email with the time and place (Appendix B). Attached to this email was a consent form and the participant was asked to send this back prior to the interview (Appendix C). Confirmation that it was signed and received was then obtained before the interviews began.

The participants were adults with no physical or mental health impairments. However, it was acknowledged that the nature of the research could cover uncomfortable or distressing topics. Therefore, debriefing forms were given to the participants after the interviews were completed (Appendix D). The participants were informally debriefed at the interview and a list was read out of the organisations they could contact if they were feeling at all distressed. After the interview, a thank you email was sent and, for those that were interviewed telephonically or via Skype, a debriefing form was included with the thank you email (Appendix E).

In the participant information sheet, the interviewees were told that they could withdraw from the study at any point up to the commencement of data analysis and that their data would be destroyed if they withdrew within this timeframe. They were also told that if they attempted to withdraw after this point, the researcher would maintain the right to use their data.

The researcher's safety was also considered. In order to ensure this, the interviews took place only via Skype/telephone or at the participant's workplace. In the latter case, the room was either in a communal area of the building or other staff members were aware that an interview was taking place there. The exit of the room was easily accessible, with the participant sitting furthest away from the door. In order to consider the researcher's emotional safety, personal therapy and research supervision were considered to express any distress caused by the interviews.

Participants

Participant Inclusion and Exclusion Criteria

Practitioners from all therapeutic and psychological professions were included. Professionals from all areas of psychology were contacted, including clinical, forensic and counselling psychology, counsellors, assistant psychologists, art therapists and drama therapists. The criteria also included any other practitioner in the therapeutic field. The participants were asked if they had worked therapeutically one-to-one with someone diagnosed with psychopathy, which could include probation as well as assessments. Potential participants would be excluded if they had not worked on a one-to-one basis with an individual with psychopathy. This would include anyone who had worked in a facility with those who exhibited traits and behaviours of psychopathy but had not worked one-to-one with them.

Recruitment

Smith, Flowers and Larkin (2009) have suggested that doctoral students should use between four and 10 participants for an IPA study. Reid, Flowers and Larkin (2005) further support this, arguing that in IPA less is often more, because fewer participant interviews explored at greater depth are more valuable than a bigger population size with a shallower analyses. Therefore, no more than 10 participants were considered for this research.

Issues regarding recruitment were encountered. Given that those who exhibit psychopathic traits and behaviour are thought to account for only 1% of the world's population, it follows that the practitioners who work with them could be few and far between (Silver, Mulvey, & Monahan, 1999). Smith and Osborn (2007) argue that in IPA purposive sampling is chosen instead of random sampling in order to recruit a population for whom the research question is pertinent (Willig, 2013). Therefore, in order to reach a broader audience in the field of psychopathy, both offline and online recruitment were used. Private psychiatric hospitals, charities, private psychology services, universities, online forums and the British Psychological Society (BPS) were approached. Six participants who consented to be interviewed were found through these avenues.

During recruitment, the potential participants were contacted via telephone or email (Appendix F). They were sent the research advertisement and participant information forms (Appendix G). After this, a number of correspondences were received from university professors on Forensic Psychology Doctorates who did not have experience with psychopathy and therefore could not participate. Charities also appeared to not work with psychopathy. The six participants included in this study were the only six found during recruitment who met the criteria.

The Six Participants

The six participants comprised of two clinical psychologists, one counselling psychologist, two forensic psychologists and one psychiatrist trained as a psychoanalytic psychotherapist. They had worked in PCL-R assessments, probation support, and one-to-one psychological therapy in a variety of services such as prisons, forensic secure wards and probation.

They varied in experience in the field of psychology from about 10 to 20 plus years. Their ages varied from the 30s to 50s and there were three females and three males.

All the participants' had dealt with clients who had been diagnosed with psychopathy, were male, had all committed crimes and were detained in prisons or secure wards when the participants worked with them. None of the participants had encountered psychopathy in the community, outside of a forensic setting or in a female client.

Procedure

Semi-structured Interviews

One of the most common ways to uncover themes and categories in IPA is through semi-structured interviews, which allow for a degree of flexibility in the data collection process, encouraging dialogue between the researcher and the participant (Smith & Osborn, 2007). Thus, semi-structured interviews were used for this study. With this method of data collection, the questions are not typically presented in any order; the researcher is free to follow the participants' interests and to explore any topic that arises. Therefore neutral, open-ended questions that were free of jargon were used to help construct further questions and exploration (Smith & Osborn, 2007; Willig, 2013). This flexibility and willingness to follow the participant was paramount in giving

the individual a voice and thus, highlight the similarities and differences within the sample (Willig, 2013).

The Interviews

As a novice interviewer, challenges arose in the first interview that were addressed in subsequent interviews. The first participant seemed extremely interested in the researcher's experience working with psychopathy and there were difficulties in deflecting this. Despite this, the interview was still included in the analysis because this did not seem to negatively impact the data. In subsequent interviews, any interest in the researcher's experience was addressed by stating that questions could be asked after the interview. This was useful because a number of participants asked the researcher's opinions of psychopathy treatment prior to the interview.

Interview Schedule

It has been suggested that novice interviewers should use interview schedules with specific questions that explore perceptions and individual experience (Appendix H) (Pietkiewicz & Smith, 2014). As a novice interviewer, the questions were reviewed before the interview and a hard copy of the interview schedule was kept during the interview (Smith, Flowers, & Larkin, 2009). However, it was important to recognise that both the content and the course of the interview could not be established in advance (Smith, Flowers, & Larkin, 2009). This meant that the interview questions were flexibly followed in no particular order (Smith, Flowers & Larkin, 2009).

Each interview began by confirming that the participant had filled out the consent form. After this, the interview began with a descriptive question about the participant's career and experience in the field of psychology in order to gain an understanding of their background. This was also an attempt to begin to build rapport

by showing that the researcher was interested but also, to begin the discussion (Smiths, Flowers & Larkin, 2009). Then each interview followed with the same narrative question: Could you tell me about your experience working with psychopaths? (Smith, Flowers & Larkin, 2009) This was a general question to open up the interview but also, to show that the interview was based on the participant's experience (Smith, Flowers & Larkin, 2009).

The subsequent questions were a series of open-ended questions to uncover what the participant felt worked in therapy, what did not work in therapy and the nature therapeutic relationship. This included a narrative question about his or her general experience in treatment for psychopathy, contrast questions about the similarities and differences of working with psychopathy versus other diagnoses and evaluative questions asking how he or she felt about treatment for psychopathy (Smith, Flowers, & Larkin, 2009). Prompts and probes were also frequently used to help the engage the participant, elicit any necessary clarifications and to explore particular areas of interest (Smiths, Flowers & Larkin, 2009). The interviews typically lasted for approximately 50 minutes to one hour.

Materials

The interviews were recorded using a Dictaphone. The participants who lived outside of London or were unable to arrange a time during their breaks at work were interviewed via Skype or telephone while they were in a familiar environment, such as their homes (Tew, Bennett, & Dixon, 2016; Levitt, Pomerville, & Surace, 2016). The recordings were then uploaded to the researcher's personal laptop in a password-protected folder. All the interviews were deleted from the Dictaphone once uploaded.

Transcriptions

Each of the interviews was transcribed verbatim by a transcription service. The service confirmed that all the recordings and transcripts would be deleted post transcription and that all the information would be kept confidential. The emails that included the recordings and the transcripts were deleted once uploaded and transcripts were locked in a password-protected folder.

After the transcriptions were completed by the service, the interviews were listened to one by one to become familiar with the transcript and to ensure that the transcription was accurate. This allowed for any nuances not captured by the transcriber, such as pauses or "umm" to be added (Pietkiewicz and Smith, 2014). During this review of the transcript, any identifying information given by the participant was anonymised and pseudonyms were assigned to the participants: Akbar, Barry, Melanie, Peter, Priya and Nina.

46 P: I really only remember one person who was a young man, very, um, sort of muscly, who was
47 like he was very worrying, the probation were very worried about him because he scored very
48 highly in psychopathy and, um, he was quite frightening actually. It was not nice being
49 around him because, uh, of this undercurrent of violence. And in fact, um, he at one stage he
50 sort of basically kicked in his door and kicked even the door surrounds and kicked the door
51 off the wall.

Figure 1: Example of Add-Ins (In Red)

Procedure

Before the analysis began, the researcher's personal opinions were owned and recognised. They were written down in a reflexivity journal in order to bracket these assumptions so that the analysis stage would not be influenced by the researcher's opinions. Below is an outline of each step taken in IPA and how these steps were conducted for this research.

Stage 1: Reading and Re-reading the Transcript

In the first stage of analysis, the transcript was listened to, read and re-read. Smith, Flowers and Larkin (2009) argue that this enables the researcher to become immersed in the data. It also prepares them for the skills needed in IPA. The authors argue that this helps researchers to slow down and discern the meaning inherent in the interviews. It also helps the researcher to see where the participant has moved from general to more specific explanations, which could provide insight into where rapport was built in the interview (Smith, Flowers, & Larkin, 2009).

For this research, before the first stage, the transcript had already been read and listened to after the full transcripts were received from the transcription service. However, when beginning this stage, the transcripts were listened to again, without aiming to make any edits or changes, while thinking back to the interview itself, in order to become familiar with the data. In subsequent readings of the transcripts, this helped the researcher to imagine the voice of the participant, which in turn helped to provide a more complete analysis of the data (Smith, Flowers, & Larkin, 2009).

Stage 2: Initial Noting

The second stage explores both semantic content and language usage, with no set rules or requirements for how to do so. The aim of this process is to increase the researcher's familiarity with the content while making a detailed set of notes on the data, covering descriptive, linguistic and conceptual comments. The descriptive comments are those that have a phenomenological focus and are close to the participants' meaning. Additionally, there is an opportunity to make more interpretative notes, which can help the researcher to understand why or how the participant has certain concerns or opinions. This particular part of the analysis requires the researcher

to look at the language used and how this may relate to the participants' life world (Smith, Flowers, & Larkin, 2009).

In this stage, each transcript was examined and notes were written in the left-hand margin, next to the participant's response (Figure 1). The language used was noted by highlighting parts of the participant's response, because this might have related to the participant's perceptions of the concepts discussed. These notes were typically structured as tentative or as questions. Descriptive comments were also noted, such as when participants explicitly stated what they felt worked or did not work in treatment for psychopathy.

Worry around those with psychopathy *Again an equate with violence?* *Frightening to be around*	P:	I really only remember one person who was a young man, very, um, sort of muscly, who was like he was very worrying, the probation were very worried about him because he scored very highly in psychopathy and, um, he was quite frightening actually. It was not nice being around him because, uh, of this undercurrent of violence. And in fact, um, he at one stage he sort of basically kicked in his door and kicked even the door surrounds and kicked the door off the wall.

Figure 2: Example of Initial Noting (Appendix I)

Stage 3: Developing Emergent Themes

As the second stage concludes, the researcher should begin to look for emergent themes. In doing so, it is important to work primarily from the notes from Stage 2 rather than the original transcript. The process requires the researcher to analyse chunks of the transcript and identify themes both from the participant's response and the researcher's interpretation of the response (Smith, Flowers, & Larkin, 2009).

In this stage, another column was added to each transcript to the left of the initial notes (Figure 2). After creating the column, the process of identifying themes that summarised or unified the initial notes began while attempting not to lose any of the meaning behind the participants' answers (Smith, Flowers, & Larkin, 2009). The columns were structured this way in order to best focus on identifying themes from the initial notes and not from the transcript itself. However, if the initial notes needed clarifying, the transcript was referred to.

Psychopathy as violent/to be concerned about	*Worry around those with psychopathy* *Again an equate with violence?* *Frightening to be around*	P:	I really only remember one person who was a young man, very, um, sort of muscly, who was like he was very worrying, the probation were very worried about him because he scored very highly in psychopathy and, um, he was quite frightening actually. It was not nice being around him because, uh, of this undercurrent of violence. And in fact, um, he at one stage he sort of basically kicked in his door and kicked even the door surrounds and kicked the door off the wall.

Figure 3: Example of Emerging Themes (Appendix I)

Stage 4: Connections across Emergent Themes

Smith, Flowers and Larkin (2009) state that this stage helps one to develop a chart of how the researcher sees the themes fitting together. They assert that this stage is not prescriptive and encourage researchers to find their own unique ways of establishing themes.

After the emerging themes had been labelled, they were written down on a piece of paper. They were then transferred to a large piece of paper and lines were drawn

between them to begin connecting them. Then certain themes were crossed out or moved to another location, while others were reworded in order to fit them into other emerging themes. After this, abstraction was used and what appeared to be superordinate and subordinate themes were recorded on a piece of paper (Smith, Flowers, & Larkin, 2009). These themes were then reviewed to ensure that all of the original themes were present. Each transcript yielded between 15 and 21 themes at this point of analysis.

Stage 5: The Next Interview

As IPA is an idiographic approach, the methodology requires the researcher to address each transcript separately (Smith, Flowers & Larkin, 2009). As the researcher moves onto each subsequent case, the same stages as above should be followed. However, it is important that the initial notes and themes from the previous transcript do not impact the notes and themes for the subsequent ones (Smith, Flowers, & Larkin, 2009). Researchers might do this by becoming aware of the notes and themes from previous interviews.

The above stages were followed as each subsequent interview was analysed. However, it was important that the initial notes and themes from the previous transcript did not impact the analysis of the subsequent transcripts (Smith, Flowers, & Larkin, 2009). Thus, general notes that were written after each transcript was read were useful. In essence, stating the themes that had been named previously enabled the researcher to bracket this data, while new themes were allowed to emerge (Table 1).

Participants	Notes
Barry (1)	Difference between those who score high and low, fear of those who score high

Melanie (2)	Self reflection important, factors important in treatment, external factors important
Peter (3)	Pessimism about therapy, all therapy, external factors most important
Priya (4)	Difference in high and low scores, self reflection important
Nina (5)	Can't change, only manage behaviour, stigma unhelpful, unofficially diagnosing people
Akbar (6)	Two types of psychopathy: intelligent and violent, reflection important, external factors important, hopeless work

Table 1: Interview Notes

Stage 6: Patterns Across Interviews

The last stage involved finding patterns across the interviews. In this last stage, all the superordinate and subordinate themes were laid out on a large table. At this point there were seven superordinate themes but about 100 subordinate themes. The labels were shifted around the table until the themes from all the transcripts were merged under distinct superordinate themes. At this point, it appeared that many of the subordinate themes could be relocated under a number of superordinate themes because they covered roughly the same topic. For example, "Reflect on Self", which represented the reflection that many participants talked about, was moved merged under "An Area of Uncertainty, Pessimism and Nihilism" and relabelled as "Vigilance towards Myself" because it appeared that this reflection came from uncertainty. Moreover, four superordinate themes were merged into two superordinate themes and the subordinate themes were reorganised below them. For example, "Upon Reflection", again talking about the reflection of the practitioner, was merged with "Vigilance towards Myself" and put under the superordinate them "An Area of Uncertainty, Pessimism and Nihilism".

Then each transcript was reviewed again and the line number that corresponded with the subordinate theme was recorded on an Excel Spreadsheet (Figure 3). The spreadsheet also detailed what the theme encompassed to serve as a reminder when going through the transcripts. Line numbers were recorded by participant and put in numerical order. This was so that, when writing the findings chapter, the line numbers would be easy to refer back to and it was clear how many participants shared similar views.

	A	B	C	D
1	Superordinate Theme	Subordinate Theme	Barry (1)	Melanie (2)
2	"There's Something Quite Powerful about That Label" (Yellow)	"Damning Label": Negative reactions to the general label of psychopathy without considering factors or scores	1.27-1.29, 1.45-1.49, 1.51-1.52,1.219-1.220, 1.222-1.227, 1.387-1.394	

Figure 4: Excel Spreadsheet: Superordinate and Subordinate Themes with Line Numbers

Notably, at this stage some researchers will measure the frequency of their themes and often remove certain quotations if their general gist is not shared by a certain number of participants (Smith, Flowers & Larkin, 2009). However, given that the research was conducted from a critical realist perspective, it seemed important to uphold the aim of giving the participants a voice, as well as honouring their subjective experiences. Therefore, no quotations were overlooked and opinions shared by even a minority of the participants can be found in the findings chapter if relevant to the themes.

At this point, certain excerpts from the interview were highlighted and colour coded to match the subordinate theme (see parentheses in Figure 3) if the quotation was particularly relevant to the theme and could be used in the Findings chapter (Figure 4).

182 R: It would happen right from the way the service was structured, right from our own kind of
183 therapy managers would pass them on. We would have client meetings and it's disgraceful,
184 really, but some of the language that would be used. You would have that kind of heart sink
185 that this person was moving into your ward or, "Why don't you try now?" and it would be the
186 sense of somebody being a burden or being a problem or being a different kind of challenge.
187 I think if we'd ever stopped and one to one we're speaking about that person in that particular
188 way, I think they would have been quite embarrassed, but it did happen an awful lot in my
189 last service.

Figure 5: Example of Highlighted Text in Transcript

However, quotations were cross-referenced with a table (Table 2). As the participants had a wide variety of experiences, this table detailed their experience in order to best keep transparency in mind for the Findings chapter.

Participants	Notes
Barry (1)	Experience with moderate in therapy and high in probation
Melanie (2)	Experience with all presentations but mainly assessments
Peter (3)	Experience with all presentations
Priya (4)	Experience in assessments, prison service work with psychopathy
Nina (5)	Experience with all presentations
Akbar (6)	Experience with all presentations

Table 2: Experience of Participants

After a number of quotations were highlighted for the Findings chapter, the data was checked a second and third time. Each line number was reviewed and cross-referenced to the transcripts to ensure that no mistakes had been made in typing out the

line numbers or assigning the lines to certain themes. At this stage, a few typographical errors were found and a few quotations were moved. However, all the highlighted quotations and those used in the findings were found to be under the appropriate subordinate themes.

Findings

This chapter comprises a description and analysis of the participants' insights into the interactional qualities of the therapeutic relationship, the therapeutic approaches they chose and how effective these treatments were. From this insight, the implications of the therapeutic relationship and interventions are discussed.

Superordinate Themes	**1 "There's Something Quite Powerful about That Label"**	**2 The "Continuum"**	**3 An Area of "Uncertainty, Pessimism and Nihilism"**	**4 Beyond "Hanging in There"**
Subordinate Themes	a. "Damning Label" b. "Badge of Honour" c. To Label or Not?	a. No Two the Same b. "Like all of us" c. Unsuccessful vs. Successful Psychopathy	a. "That's Really Chilly, isn't it?" b. The Impossibility of "Genuine Internal Change" c. "Vigilance towards Myself"	a. Overcoming the "Troughs" b. Nothing to do with Therapy c. "Challenging Them"

Table 3: Table of Superordinate and Subordinate Themes

Superordinate Theme 1: "There's Something Quite Powerful about That Label"

In reflecting on working with clients with psychopathy, all the participants alluded to the power that a label such as psychopathy held for both themselves and their clients. During their interviews, many of the participants referred to psychopathy as a label that could illicit both positive and negative reactions, with some of the participants' clients being proud of the label or finding comfort in it, while others found it distressing. Similarly, practitioners shared their reactions to the label, with some recognising the stigma and fighting against it. Below, Nina describes the status of the

label among the clients she encountered while also, acknowledging the *"damning"* side of the term.

> *But I think it's a bit of a* ***badge of honour*** *as well. I remember another patient who – I don't know if you've ever seen the pens that say,* ***"I'm a perfect 40."*** *Have you seen those? (Interviewer: No) So it can be* ***a bit of a thing****, like, if you're really high scoring, then that's* ***something to be proud of****. I've certainly worked with people who have achieved a high PCL-R score and see that as a* ***really good thing****. Because they're not* ***just a bit antisocial****,* ***they're a proper full-out psychopath.*** *They really enjoy that term and* ***the kind of kudos*** *that it brings. It's a bit of an odd one, it can be* ***quite damning*** *but people can also* ***really enjoy it.***
> *Nina, 5.70-5.78*

Here, Nina brings the supposed achievement of psychopathy into the physical world, stating it as a *"badge of honour"* and using the *"pens"* as a physical representation of the badge. The excerpt suggests that psychopathy itself may be viewed as a reward to be *"achieved",* as though the client had worked hard to move beyond being a *"bit antisocial"* and to *"a full out psychopath"*. Nina also seems to emphasise this acheivement by repeating *"really"*. Moreover, Nina appears to minimise some of her statements with words such as *"a bit"* and *"just"*. Throughout her interview, Nina appeared to fight against the stigma of psychopathy, even standing up her own colleague's assumptions. Here, it is as though Nina may be experiencing a conflict between accurately depicting the immense achievement felt by her clients whilst also, trying to minimise this *"badge",* perhaps fighting against a highly stigmatised depiction of a callous individual, prideful of their antisocial nature. It may be that if clients are particularly proud of having psychopathy and, as Nina suggests, they "*enjoy"* it, there might be little motivation to change or engage in therapy. Moreover, the degree of pride in being *"antisocial"* which Nina suggests might hinder the appeal of acting in pro-

social ways, which could impact the ability to build a therapeutic relationship or even the client's willingness to learn new ways of acting. Here, it appears that practitioners and clients' impressions of the diagnosis might be opposite, possibly creating a conflict between the two.

Additionally, Barry explained the dichotomy between positive and negative reactions to the term as well. He had described an instance when working in probation, in which a client with psychopathy had kicked in his own door. Throughout the interview, Barry shared both the fear and uncertainty in reference to psychopathy and it's presentation. In the current excerpt, he appeared to be unsure of his own level of safety around such violence, which previously he had believed stemmed both from his inexperience with the diagnosis and the level of violence exhibited by the client.

> *…I think at that point I was* ***quite frightened****, um,* ***about psychopathy*** *and* ***not knowing much about it****. Um… and then in* ***the prison it was fine****… I think they were quite contained in the prison, um, and I think they had* ***quite a high status*** *amongst most of the prisoners. And we had one chap who came into our group talking about how he had been* ***cutting up someone in a bar****, um, and it was* ***quite strange to hear*** *but he* ***didn't feel worrying in terms of my own personal safety*** *because I think the guy felt very* ***contained*** *and he was talking about it in a way, you know that, I think he* ***enjoyed the fact that people kind of respect him*** *or not respected but* ***looked up to him****.*
> *Barry, 1.53-1.61*

Here, a conflict in Barry seems to be apparent. Although he had previously emphasised the fear and uncertainty he felt around psychopathy, it appears that the prison environment, where Barry believed a client of his felt *"contained"*, helped Barry to overcome his fear and connect with how *"strange"* it could be to hear someone boasting about their crime, as though this were a unique aspect of the diagnosis and he had not experienced this previously. Moreover, it seemed as though this lack of fear

allowed him to reflect on his client's status and how others *"looked up to him"*. Thus, it appears as though having this containing environment, where personal safety is not a concern, might have aided Barry in his work. It may be that the delivery of interventions and sustaining a therapeutic relationship is made easier as well, as the practitioner would not be distracted by safety concerns and thus, might be more able to focus.

Despite this, the *"badge"* could equally inhibit the therapeutic work. This pride might result in little motivation for the client to change their behaviours to those that would not be praised by others. Additionally, it may lead to a compromised ability to admit vulnerability or weakness when the label is viewed as *"powerful",* both of which are important to therapeutic outcomes.

Subordinate Theme 1a: Damning Label

The majority of the participants shared experiences that brought them into contact with the *"damning"* impression that the label could elicit. The participants described instances in which clients and colleagues alike indicated that they had experienced this.

Nina, having begun her psychology career outside of a forensic setting, described a level of shock at the prejudice apparent when discussing clients with psychopathy. During her interview, Nina often passionately spoke against this prejudice and here, expanded on her experience, explaining how many of her colleagues would seem to equate the label *"psychopath"* with dangerousness, a phenomenon that was present throughout many of the interviews in this study.

> *So he stopped having this great kind of* ***myth****, um, because I was certainly* ***very conscious*** *of that when I first started working with him. The handover I got from a colleague was very much kind of,* ***"Oh, he's really dangerous and he's a psychopath and you have to watch him."*** *Actually, in practical*

terms… ***the risk that he was posing was perhaps lesser than some of our other patients*** *that* ***didn't happen to have that attached to their diagnosis…***
Nina, 5.65-5.70

Here, there appears to be conflict between Nina's perception of her client and that of her colleagues. Her colleagues seem to suggest a type of vigilance that was recommended for work with this particular client, a vigilance that Nina may have perceived as entirely fictional as a "*myth"* is. Nina explains that she was *"very conscious"* of this perception and how, in reality, the *"myth"* did not exist because her client's risk was *"perhaps lesser than… other patients"*. It seems as though Nina became more aware of this widely held but fictional representation of her client's dangerousness referring to it not only as a *"myth"* but also, prefacing with a minimiser such as *"kind of"* (and using this again later to describe the handover). This word choice may suggest a lack of belief in or understanding of her own colleague's biases which Nina continuously alluded to throughout her interview. It may be that if practitioners share her colleague's perception of the client, it could create a barrier to building a trusting therapeutic relationship, if a practitioner is particularly concerned about their safety. However, to Nina her client was no more of a risk than the other clients. This does pose the concern of conflicting perceptions of clients and how these discrepancies could impact the approach treatment. It may be that certain opinions could possibly be overridden and a focus on dangerousness could distract from helpful approaches that address motivations, weaknesses, and limitations of the client.

Priya, on the other hand, shared an experience in which this dangerousness could be present. Priya explained that after having built what she thought was a good therapeutic relationship, in the minority of cases, she witnessed that the label could evoke threats from the client.

*Anger in that **I've duped them**, and I've **tricked them into doing the assessment**, that now it's going to be used to **deny them release or deny them parole or deny them treatment**… it's been **legal threats**, [like] "I'm going to **report you** to whoever **or sue you**", to **verbal threats of harm**, kind of like, you need **to leave the room right now.***
Priya, 4.346-4.350

Here, it appears that Priya's clients felt "*tricked"* as though Priya may have had an intention to deprive them of services suggesting perhaps a broken trust between herself and her clients. It may be that the clients knew the negative perceptions of the label, possibly informed by the prison itself, as the prison excluded those with psychopathy from the drug rehabilitation programme. Priya also repeats "*deny",* emphasising perhaps the intensity of the interaction or the extent to which the clients or even Priya believed individuals could be denied or excluded from services. As Priya describes, the threats could become so severe that one would *"need to leave the room right now"* which suggests a sense of urgency and imminent danger. Considering the reaction Priya describes, it may be that exclusion from programmes as commonly practiced could be problematic. It may be that, given the traits and behaviours of psychopathy, individuals might struggle to express discontent with the diagnosis and the consequences of having it as is seen with Priya's experience. Subsequently, this reaction can rupture the therapeutic relationship and possibly perpetuate an association of violence with the client. This, in turn, might further deprive a client of the services they need.

The participants in this study appeared to acknowledge the *"damning"* element of psychopathy, which seemed to come with a level of prejudice that both the practitioners and clients recognised. This prejudice might have, in turn, negatively impacted the building of a trusting therapeutic relationship and the ability to make decisions regarding interventions treatment which could lead to depriving a client of

further treatment. Despite these reactions, it appears that many clients wore their labels with pride.

Subordinate Theme 1b: "Badge of Honour"

In contrast to the seemingly negative reactions that many of the participants described, almost all of them shared that many of their clients seemed to wear their label as a *"badge of honour"*. The participants explained that those who scored high on the PCL-R were accorded a status in their facilities that many of them enjoyed.

During her interview, Nina explained that many of her clients with psychopathy (particularly with higher scores) were patient representatives in their facilities possibility due to their *"status"* (5.414-5.427) and that many of them took pride in their diagnosis.

> *I think some people do wear it as a **bit of a badge of honour** because they would **rather [have] that term than schizophrenic** applied to them or, you know, **depressive or any kind of mental health term** which is [sighs] I think if you had to choose, maybe for some people **psychopath is less stigmatising** in some respects, because it's a **more powerful term**. Yea, I think that's probably what it comes down to; there's **something quite powerful about that label** in a way that you **don't get with other mental health diagnoses**.*
> *Nina, 5.90-5.95*

Here, Nina appears to recall her own perceptions of why psychopathy may be a *"badge of honour"*. Throughout the excerpt, Nina seems to reflect, perhaps just realising that the pride of psychopathy may be, in part, due to the implied powerlessness of other *"mental health term[s]" ("Yea, I think that's probably what it comes down to")*. Nina sighs at this notion, pausing and suggesting hesitation before sharing that psychopathy may indeed be *"less stigmatising"*. Nina also uses the phrasing *"if you had to choose"* implying that either option, psychopathy or mental illness, would be chosen by force

("had to") and that neither would be willingly chosen. As previously stated, some individuals might take pride in their diagnoses and thus, lack motivation to change. Nina in particular pointed this out, saying how *"we want to change them"*, not that they want to change (5.482-5.484). However, the *"honour"* that comes with this may differ. If a client is particularly proud of his or her diagnosis purely because its nature is more powerful than a stigmatised mental health illness, there might be an assumption on the part of the practitioner that this pride could mean they are unwilling to change when, in reality, they might be. However, if an individual views mental illness as particularly weak in comparison to psychopathy, engaging with therapeutic treatment might be seen to imply weakness as well. Thus, treatment could prove difficult in these cases as well.

However, as one participant described, there appears to be an alternate way of experiencing pride in the label. Melanie had a great deal of experience in conducting PCL-R assessment and thus, was able to give valuable insight into her experience with the tool. While Melanie was discussing the importance of insight into achieving positive outcomes, she mentioned how some of her clients experienced a level of comfort from their label.

> *…I've worked with other men where I, I have gone to give feedback about the assessment and particularly if it's a high score and have been met with a response of,* ***"I knew there was something different about me."*** *So, often it's not a* ***complete surprise to them*** *and it helps them to* ***make sense of some of the experiences they've had.***
> *Melanie, 2.124-2.127*

Here, it appears that Melanie believes that the PCL-R could give valuable insight to the client and implies that her client's awareness of their own difference predates the assessment itself, as if they had felt *"different"* for some time. Melanie states that this reaction is true *"particularly if it's a high score"* perhaps indicating that this difference

felt by the client may be especially prominent in those with higher scores. As discussed by almost all of the interviewees and Melanie herself, the presentation of those with high scores or those who loaded on Factor 1 was particularly striking. Thus, this reflection seems to be in line with those of the participants and Melanie alike. It may be that clients who feel this comfort might be more willing to connect and to perhaps engage in treatment which may further improve this insight and impact treatment outcomes. This may highlight the importance of conducting an assessment for the insight of the practitioner and client alike.

Subordinate Theme 1c: To Label or to Not?

Although the majority of participants described PCL-R profiles as a useful means of informing therapeutic work, half of them also reported instances in which assessments were not carried out for clients who displayed traits and behaviours of psychopathy. It seemed there was an innate suspicion as to which clients might have psychopathy and this feeling was enough to confirm the diagnosis without an assessment. Below, Priya discusses this feeling.

> *So, it's hard to know whether that's **about personality profiles**, or it's probably a bit of both, but I think **the environment** plays into that as well. Just thinking about the people on my wing in a **high secure prison**, they tend to all, not all but mostly **present as one, present the same**. There's this **bravado**, you know there's just an **image that you have to present to the outside world**. You could walk onto a wing and talk to a few people and not have any idea **who might be a high scorer and who might not**. Whereas I think here, if you had someone that scored above the cut-off and was on a ward here, you could walk onto the ward and you'd be able to **pretty much point that person out, after a few conversations**.*
> *Priya, 4.424-4.431*

Priya indicates that the prison "bravado" may lead individuals to *"present as one",* almost suggesting that the prisoners themselves may form a type of united front. It sounds as though clients can blend into the crowd with a possible boldness intended to intimidate implied by the word *"bravado".* Priya uses the phrasing *"you have to present"* as though this *"bravado"* were not necessarily voluntarily taken on and that it may be a type of defence or means of survival. Priya suggests that this presentation would make it particularly difficult to identify those with psychopathy because the presentation may appear similar to those in the prison system. However, in inpatient wards, Priya explained that those with psychopathy may have a presentation so distinct that only *"a few conversations"* would be necessary to point them out. However, assigning a label to an individual exhibiting some traits and behaviours of psychopathy without a formal diagnosis might create false perceptions. This could, in turn, result in the promotion of treatments that are not effective for diagnosable psychopathy and possibly only for certain traits and behaviours. Moreover, given the stigma attached to the diagnosis, it could have implications for how this individual is perceived or treated, as psychopathy is usually equated with dangerousness or an exclusion criteria for certain treatments.

Although earlier Barry had suggested that assessments may be useful in highlighting risk for those with higher scores, he appeared to agree with the type of innate feeling that Priya explained, suggesting that assessments were unnecessary some of the time. Later in his interview, when asked to elaborate on why, he alluded to stigma.

> *…**my worry** is when you have **formal assessment** people **get labelled with things** and then they get treated as a kind of **shorthand**, "Oh this person should be **antisocial PD or whatever**," which I **don't always think is always very helpful**. Because, actually, we are there to see what we can do to help at the level of **intrapersonal and interpersonal functioning.***

Barry, 1.197-1.200

Barry appears to explain a *"worry"* that clients may be reduced to their diagnosis, such as "*antisocial PD"* or psychopathy. He alludes to the stigma associated with both perhaps implying that the label and the perceptions that comes with it are often times not *"very helpful"*. Barry seems to suggest that this may distract from what Barry considers to be more relevant and important, their "*level of intrapersonal and interpersonal functioning*". As discussed by many of the participants, with Barry included, the diagnosis seemed to come with the implication that interpersonal functioning would be very challenging (especially for those loading on Factor 1). Thus, it appears as though Barry may want to avoid this type of assumption and as he states, focus on this type of functioning independent of the assumptions made of psychopathy. Although this may be well intentioned, this lack of formal assessment could again create false perceptions of psychopathy and unhelpful interventions. Additionally, as the PCL-R itself can help to point out issues in intra and interpersonal functioning the assessment may be helpful in some instances. Furthermore, it may deprive practitioners of a valuable piece of information that could be provided by the PCL-R as this profile could help practitioners to make decisions about treatments based on which factors the individual scores on.

In contrast to Barry's perception, Nina argued that this shorthand was used in an unhelpful way even without a formal assessment having been carried out. Here, Nina passionately shares an instance where she appears to have had to fight against the term "psychopath" being used incorrectly.

> *So once I had trained in PCL-R, I remember* ***pulling actually a psychology colleague up*** *in a ward round, who sat there saying that somebody was a psychopath: "Actually,* ***you've got no business*** *making that kind of claim.*

> *You* ***haven't assessed this****. You know, you might be suggesting that they're a* ***particular trait*** *that you're picking up on, but* ***you don't get to use that term*** *and that's* ***not a helpful way of expressing it anyway.****"*
> *Nina, 5.45-5.50*

Here, it seems that Nina recognised the stigma associated with the label *"psychopath"* and wanted others to exercise caution when using it. Speaking with conviction, Nina reflects her passion when she explains how she *"[pulled]… up"* her colleague, telling them they had *"no business"* using the term without an assessment. It also appears as though Nina is mindful of using the term *"psychopath"* calling her colleague's use *"unhelpful"* perhaps referring to the stigma associated with it. Here, it may be that this incorrect use of the diagnostic label might perpetuate the *"myth"* and association of dangerousness she spoke of in the interview. As mentioned earlier, it may be that this prejudice could again create false perceptions of psychopathy, result in an application of unhelpful treatments and also, a possible exclusion from certain treatments thought to be ineffective for psychopathy.

From the participant's experience, it seems as though the label of *"psychopath"* had quite prominent yet diverse effects on people, with some viewing the diagnosis as a *"badge"* to be worn with pride and others as a mark of dangerousness, or even as a means of being deprived of treatment or release. This diversity in reaction appears to have potential implications for treatment in psychopathy, in that the presence of worry or presumption of violence might impact therapeutic relationships and interventions Additionally, a lack of assessments may encourage false perceptions of the diagnosis and, possibly, unhelpful treatments.

Superordinate Theme 2: The Continuum

Similar to the diverse effects the label could have, all the participants in this study suggested that psychopathy could operate on a type of continuum, implying its heterogeneity. They pointed out the diversity in psychopathy whilst some made comparisons to the wider community. Additionally, most of the participants made the distinction between what many of them called *"successful"* or *"unsuccessful psychopaths",* stating that they had only encountered unsuccessful individuals in their work in forensic services.

When discussing the factors present on the PCL-R profile, Melanie mentioned the diversity within psychopathy.

> *...you can have* ***two people with the same score****, but they would look* ***very, very different*** *and I think I'm much more focused now on... the* ***profiles of individuals****... and what that tells me about them and how that fits, so I'm* ***building a picture of them rather than thinking about [their score]...***
> *Melanie, 2.397-2.400*

Here, given Melanie's extensive experience with the PCL-R, she seems to imply that the PCL-R score alone might not provide adequate information about an individual's presentation. Melanie seems to suggest that the score may reduce a person's characteristics and needs to a score, as though the number is not fully representative *("rather than thinking about their score").* Repeating *"very"* perhaps to emphasise the unique features of each presentation, Melanie promotes viewing the individual profiles as a means of *"building a picture"* of a client. She also seems to imply that the PCL-R itself may be comprehensive enough to build *"a picture of them"* perhaps indicating how extensive and thorough the assessment is. This could, in turn, create concerns for those who focus on the score to inform both their perceptions and their treatment choice.

Additionally, when talking about the difficulty in working with psychopathy, Nina, similar to Melanie, pointed out the importance of not distinguishing between those who score high or low because she argues that the Factor 1 and Factor 1 scores are the most important.

> *I'm* ***conscious*** *of saying* ***"with higher scores",*** *because I think there's a* ***difference between the kind of facet scores*** *and whether you're thinking more about the* ***interpersonal impact of psychopathy*** *or* ***the antisocial side of it****. I mean,* ***antisocial feels fairly straightforward*** *and it feels more* ***like a lot of our forensic clients*** *across the board and antisocial personality disorder. It's something more about* ***the interpersonal relationship within psychopathy*** *that I think I find most* ***striking and perhaps most difficult to work with****.*
> *Nina, 5.151-5.154*

Nina shares her own awareness of the difference between a high and a low score versus Factor 1 or 2 loading. With her use of *"I'm conscious",* she implies a cautiousness around making assumptions based on scores. Nina also suggests that the commonality of antisocial personality disorder may lead to treatment being more *"straightforward",* giving the impression that the intervention itself may be less complex and more direct. However, she seems to emphasise that the interpersonal aspect of psychopathy, reflected mainly by Factor 1, is most *"striking"* or perhaps complicated. This comment may indicate why it is that she is *"conscious"* as the score itself would not reflect this element. It may be that Nina's reflections may be a useful guide because, according to almost all the participants, the manifestation of these traits may require further thought, adjustment in treatment, and even, greater resilience. However, this impression of Factor 1 might also create apprehension on the part of the practitioner if a client has a high score on Factor 1. This apprehension, if palpable, could in turn impact the therapeutic relationship or even, the intervention itself, in that the practitioner may have

difficulty maintaining hope. Moreover, any awareness on the part of the client about this perception of Factor 1 scores may create a level of pessimism within them and negatively impact treatment.

In short, the concept of diversity in psychopathy was tangible in the interviews. However, the way in which the participants explained this difference came with its own unique elements, with some distinguishing between high and low scores and others between Factor 1 and Factor 2 loading. However, it appears that depending on a score and not the individual Factors upon which it is based could create an inaccurate picture. Moreover, the troublesome depiction of Factor 1 could create apprehension on the part of the practitioner or pessimism on the part of the client and thus, negatively impact treatment.

Subordinate Theme 2a: No Two the Same

All the participants described the various factors found on the PCL-R, how these vastly impacted their client's presentations, how these informed the way in which their clients were viewed and how they were approached therapeutically.

From the start of her interview, Melanie indicated that the PCL-R profile could vary so significantly that it could present itself differently depending on which Factors her clients' predominately scored on. Below, Melanie explains how Factor 1, the interpersonal aspect, could impact a client's response to treatment.

> *I think, uh, probably if I reflect back on, um, the people that I've worked with, people who score on the **Factor 1** have had **far more difficulty engaging in mainstream programmes,** just the whole **learning style is really different**. They, they experience difficulty **engaging with the group**, um, and **facilitators, the content of the material** and again it becomes difficult because if there are other **personality disorders present**, again that, you know, **will impact** on how they look in treatment.*
> *Melanie, 2.76-2.81*

Here, Melanie implies that the PCL-R profile could be helpful to decide which type of intervention to use. More specifically, she states that with those who score highly on Factor 1 have *"difficulty engaging in mainstream programmes"* as their "*learning style"* is different. Although Melanie doesn't expand on this *"learning style",* she does point out that these individuals may have difficulty engaging with others (the group and facilitators) implying that there is a struggle with interpersonal functioning. Melanie emphasises this struggle repeating difficult/difficulty three times throughout the excerpt. However, she also appears to hesitate quite frequently saying *"uh"*, *"um"*, and *"you know"* perhaps implying an uncertainty with her statements. This may be because Melanie had worked primarily in assessments.

However, considering the difficulties with Factor 1 scores, as mentioned previously, this could evoke a sense of apprehension in the practitioner or even pessimism within the client themselves. This may, in turn, hinder the development and maintenance of a therapeutic alliance as well as the outcome of effective therapeutic intervention.

Priya reflected on a similar unique challenge, but rather than stating the difference between Factor 1 and Factor 2 presentations, she suggested that the difference might have to do with the score.

> *…I guess I'm thinking about* ***someone's ability, willingness to self-reflect****… so I think there is a* ***capacity thing*** *with people* ***who score high*** *on the PCL-R, it's not necessarily that they're just cold and they don't want to do these things, like* ***reflect, be aware, feel****, it's just* ***they don't have the capacity to****, there's a* ***real lack of ability*** *to do these things, um, and you can try and help them with that, you* ***can try and help them to develop those skills****, um, but it's going to be a* ***hard slog*** *and it's going to be* ***really, really difficult for them*** *and you're going to* ***see that it's going to be difficult for them.***
> *Priya, 4.392-4.399*

Here, Priya indicates capacity. She repeats *"capacity"* twice whilst also mentioning a *"lack of ability"* all emphasising the idea that those with psychopathy may be severely lacking in certain areas, especially those that facilitate reflection, awareness, and feeling. She goes on further to highlight the *"difficult[y]"* they may experience, repeating the word twice, emphasising a sense of hopelessness in therapeutic work with those with psychopathy. Priya also adds that the work may be a *"hard slog"* perhaps implying that working with a lack of capacity will be taxing for both the client and practitioner alike. This may be an important aspect for the practitioner to consider in that they might want to understand what aspects their client can improve on which could provide an opportunity for positive reinforcement. This might also allow for the practitioner to be empathic towards their client's struggles, knowing this may come from a lack of ability. However, the idea of lacking *"capacity"* could also evoke pessimism on the part of the practitioner in that they might believe that change is impossible, posing the issue of whether or not treatment should be conducted. Moreover, if clients are aware of this notion, it may similarly result in a level of pessimism concerning change. Thus, there is a possibility that this could create a barrier for the practitioner in terms of building a therapeutic relationship and engaging in therapeutic interventions.

In short, when describing the spectrum of traits, the participants suggested that there were unique features between the Factors and the scores, which set PCL-R profiles apart. This highlights the importance of the PCL-R in individualising treatments to be more effective for the client. However, these profiles and the assumption that Factor 1 scores or those with high scores are much harder to treat could evoke apprehension and possible pessimism in the practitioner and client, which could disrupt both the therapeutic relationship and the treatment.

Subordinate Theme 2b: "Like All of Us"

Despite there being distinct features in psychopathy, a number of participants likened certain characteristics to that found in the community. Additionally, a number of the participants assigned this overlap to psychopathy's similarities within ASPD.

Below, Nina describes both the differences and the similarities she observed in a room with clients with psychopathy.

> *Yes, you wouldn't walk out and just think, "Okay, so that's features of histrionic and narcissistic personality disorder." It still didn't feel the same as that, it* ***would still feel radically different****. There would be some people where their team would be saying,* ***"Ah, he's a psychopath",*** *and you'd sit there and think, "Well, I don't think he is****, I think he's just highly antisocial."*** *So I've seen them kind of* **go the other way***, um, where people* ***perhaps blur the individual aspects****.*
> *Nina, 5.385-5.390*

Here, Nina details the split between the *"radically different"* aspects of psychopathy and the aspects which colleagues *"blur"*. Nina emphasises how she had felt that psychopathy itself was distinguishable in its presentation. In contrast, she found that her colleagues perhaps had difficulty distinguishing between purely antisocial traits and those of psychopathy. However, referring to a client without psychopathy as *"highly antisocial"* may imply that psychopathy itself is extremely antisocial in its presentation and that this is perhaps what leads to her colleagues blurring the *"individual aspects".* Again, Nina seems to speak out against this blurring, showing both her confidence and her understanding of the unique features of psychopathy. It is possible that this could create uncertainty in treatment approaches because if this difference results in no basis for comparison with other treatments, it might be difficult to ascertain which treatments to use in the first place. This blurring may also create false perceptions of the diagnosis

but could also suggest that the ability to *"blur"* these aspects signals the need for a re-evaluation of the similarities between psychopathy and ASPD.

Similarly, throughout his interview, Peter appeared to highlight the generalisability of psychopathy to mental health diagnoses, both in presentation and in treatment approach, stating that although psychopathy's presentation may *"[guarantee] to frustrate"* it was not the only one that could (3.524-3.525). When discussing the benefits of Robert Hare's (2003) PCL-R being constructed as a continuum, Peter pointed out that traits and behaviours of psychopathy were present throughout the population.

> *…**you and I are both psychopathic to various degree**s. [Interviewer: Mmm.] Um, so why does that matter? Well it only matters to me personally because I really do not like the idea that A. psychopathy **is something that happens inside people** and B. that it is actually **only applies to some people and not others** because as **a psychologist** I don't think that is a, uh, **legitimate way of looking at anything actually.** So I see it very much as a **continuum,** OK?*
>
> *Peter, 3.39-3.45*

Peter, as a university level psychology lecturer and practitioner with over 20 years experience, seemed confident and sure of himself when arguing the idea that psychopathy lie on a spectrum, even dismissing the notion that it did not. He appeared to be quite passionate about applying psychopathy to the general population (*"because I really don't like the idea"),* perhaps trying to minimise the stigma we discussed in the interview. Peter even goes to extend traits to both him and myself, perhaps making the traits more relatable and accessible. Peter enlists his profession as a psychologist, a specialised practitioner in mental health, to support and perhaps legitimise the idea of a spectrum which is pervasive throughout mental health. Furthermore, Peter downgrades

any view apart from the spectrum, claiming it is not a *"legitimate way of looking at anything actually"*. Considering that psychopathy carries a stigma, Peter's notion of a *"continuum"* might have a positive impact on the field because it normalises these features to the general population. This, in turn, could provide greater understanding of the condition, opening up the possibility for treatment approaches (which may work in the community) and further examination of the diagnosis, for lack of belief that the condition is in a way, untouchable.

When considering the generalisability of certain qualities, the participants implied that those with psychopathy could be quite similar to others in the community, both normalising the attributes of the disorder but also likening it to ASPD. Although normalising this to the community could render those with the diagnosis more approachable, it might also blur the lines between ASPD and psychopathy, which in turn could create false perceptions of the diagnosis and thus, unhelpful approaches to treatment.

Subordinate Theme 2c: Unsuccessful vs. Successful Psychopathy

The idea of the "successful psychopath" appeared to be one way in which the majority of the participants generalised certain components of psychopathy to those outside forensic settings. For the participants, it appeared that these individuals shared the same traits as their own clients but were *"successful"* in that they had found pro-social ways of directing their behaviour.

As Peter began sharing the progress he was able to make with certain clients, he also mentioned the idea of the *"failed psychopath"*.

> *I am strongly of the view that in terms of, um, Hare's, um, psychometric assessments you are* ***dealing with people who are running the country*** *and who are* ***psychopathic****. So let me just tell you, in many ways* ***criminals and inpatients are failed psychopaths.*** *The* ***successful ones*** *are in* ***government***

> ***and business** and maybe **the local NHS trust**. And we just sort of ignore that! And that is because if you are a really smart psychopath what you do is you become successful in **business or run a university or whatever.***
>
> *Peter, 3.437-3.442*

Speaking in absolute statements and quite confident in his notions, Peter discusses the idea of a *"successful"* psychopath. Here, Peter raises his voice and exclaims how *"we sort of ignore"* the idea that the *"psychopath"* in the forensic system is what he calls a *"failed psychopath"* and that there exists in society a *"successful"* psychopath; as though this were an obvious phenomenon society seemed to be missing. Peter appears to imply the tendency to *"ignore"* may be due to the successful psychopaths ability to be *"smart"* and perhaps disguise themselves in a powerful position in society. This perhaps implies that their success is not just due to their own intelligence but also their ability to blend into society by redirecting their traits into leadership. This disregard of successful psychopaths could again create a type of false perception by continuing to equate psychopathy and crime, ignoring traits and behaviours that might be used for success. Furthermore, the distinction between the two, if found, may provide valuable insight of how to redirect antisocial impulses into pro-social behaviour.

During their interviews, Barry and Nina explained that an individual needed more than just psychopathy to be "risky", indicating that psychopathy does not need to mean criminality. Additionally, as Barry was reflecting on the generalisable and distinguishing traits of psychopathy, he argued that there might be a social utility to psychopathy.

> *I think psychopathy is probably **required in society**. There are times and places throughout **evolutionary history** where you probably **needed the***

psychopath *to do things in order to keep the* ***tribe or the community going*** *in certain ways. They were the ones who* ***led you into battle against the neighbouring tribe****…*

Barry, 1.277-1.280

Although Barry had seemed to initially be frightened of psychopathy in his early career, it appears that he was still able to reflect on the possible use of traits of psychopathy. This depiction of psychopathy appears to be in direct conflict with the callous accounts of violence that Barry had originally shared (*"cutting up someone in a bar").* Yet, Barry seems doubtful of his assumptions with *"I think"* and *"probably"*, perhaps recognising this conflict or reflecting his own uncertainty at the notion which depicts *"the psychopath"* as a hero rather than the villain. This notion may be able to show that features of psychopathy can be used in pro-social ways, distancing itself from the idea that treating psychopathy may be hopeless. It might also support the idea that clients may be able to redirect their impulses, again providing hope for intervention. Moreover, it normalises these traits and behaviours, showing their commonality and necessity, perhaps allowing for the term to carry less fear with it.

The participants' experiences undoubtedly shine a light on the notion that psychopathy has both distinguishing and generalisable qualities. It appears that generalisable traits might create false perceptions of psychopathy and thus, unhelpful treatments. However, generalisability might also normalise the traits and behaviours of psychopathy, possibly making the task of treating the condition less daunting. Moreover, *"successful psychopathy"* might provide a sense of hope for the possibility of rehabilitation.

Superordinate Theme 3: An Area of "Uncertainty, Pessimism, and Nihilism"

All of the participants in this study described experiences with psychopathy as being laden with *"uncertainty, pessimism and nihilism"*, as Peter explained it. The participants described instances in which they felt their therapeutic work might be pointless or hopeless and that the possibility of therapeutic change appeared to be nearly impossible. Additionally, almost all of the participants described how, within these challenges, a vigilant approach to them was vital, relying on gut feelings and reflections to continue their work.

Below, Barry describes how his own scepticism about his client's motivations led to the use of reflection in his work with those who scored moderately and, potentially, with those with high scores.

> *And **I would still disclose information**, but I would be much more thinking about **why someone is asking me** rather than going, "Oh I think they are just interested because they don't get out much." I would be much more thinking, "I wonder **what this person is going to do with this information?"** Um, I guess, so that would be much more **uppermost in my mind**. And in all my work I try to think about the **transference and countertransference** and I would think of that as well, because I do think that as well, um, with psychopaths that the countertransference can be quite important. **Thinking about how they make you feel**, um, and **if you start to feel quite worried** I think that can be **quite a good signal that something could be up.***
>
> *Barry, 1.141-1.149*

For Barry, it appeared that this vigilance was related to keeping himself safe. He appeared to be in fear of his client's use of personal information, doubting their motivations and suggesting that the information may be used with malicious intent.

Barry repeats the words *"think/thinking"* perhaps referring to the level of thought, consideration or reflection that was used during his work. With his use of *"quite",* repeated twice, Barry seems to insinuate that this *"worried"* feeling is almost a certain or absolute *"signal"* that *"something could be up".* However, this lack of trust and resistance to disclose information may create a potential barrier in building and maintaining a trusting therapeutic relationship that the client may become aware of. Moreover, this may then impact engagement in therapy as the practitioner may be preoccupied with safety and the client may disengage, knowing their therapist does not trust them.

Similarly, Akbar shared that considering transference was important to his work.

> *…I mean I had this feeling a lot, even when I'm sitting with them in the room,* ***"Shall I just end it?"*** *so it was* ***very challenging.*** *[Interviewer: It almost sounds like it was kind of a, "What's the point of being here?"] Yea, that's yea… I used to* ***feel it a lot.*** *But again, it's* ***quite complex*** *as well because you get the feeling and you* ***try to reflect where is it from****,* ***is it me, is it him?*** *And um, you try to* ***reflect as well****, what* ***shall I do with the feeling?*** *Shall I* ***put it back to him?*** *Shall* ***I sit with it?***
> *Akbar, 6.69-6.75*

Akbar's uncertainty was quite palpable in this excerpt. As a psychoanalytic psychotherapist, Akbar expressed how paramount this was to his practice throughout his interview. Here, in only seven lines, Akbar poses six questions to himself and repeats *"reflect",* bringing to life the confusion and uneasiness he had felt in the room with some of his clients. Even with his experience, it was as though he could not find a way to approach the work or even an answer to whether or not he should continue the work making the hopelessness palpable. Such a sense of hopelessness and uncertainty that Akbar mentioned could impact treatment in that the confidence and wellbeing of the

practitioner might be compromised. They might, in turn, struggle to build a relationship, adequately deliver treatment or to make decisions concerning treatment or interventions to use. It may also be that practitioner burn out could be a concern. Moreover, if the client was aware of this hopelessness, they themselves may disengage.

It appears that, even when the transference might be difficult to interpret, being vigilant about one's feelings is an integral part of working with psychopathy. However, it does seem that this reflection can often uncover feelings of hopelessness, which could affect the practitioner's ability to engage in treatment with their clients and even to build a therapeutic relationship.

Subordinate Theme 3a: "That's Really Chilly, Isn't it?"

Many of the participants shared an air of hopelessness in both their therapeutic relationships and the therapeutic interventions used. They shared intimate details of feeling disheartened and deskilled, as though their work had been inadequate and even suggesting that continuing their work seemed futile.

While Nina was sharing what she described as an "inadequate" therapeutic relationship, she appeared to reflect on being deskilled.

> *Not a* ***real relationship****, not really feeling like I was* ***delivering therapy****, not* ***being good enough****. Yes, I suppose* ***I don't know what would have been enough****. I'm* ***not sure there is an enough*** *in that respect, but knowing that I was* ***never going to meet it****. Um, yea, that's really chilly, isn't it?*
> *Nina, 5.435-5.438*

Nina, who always spoke quite passionately about her work, seemed to be questioning her practice repeating the negative *"not"* several times. Here, her sense of inadequacy, much like Akbar, was evident. Repeating the word *"enough"*, she raised questions as to whether or not her relationship with her client, and the work as well, was *"real"* or even

"good". The use of the word *"chilly"* suggests a cold, disconnect with possibly the relationship and the work itself, painting a picture of Nina not knowing where she stood with her client or even how to approach the work. Such ambivalence and confusion as Nina described could impact practitioners' ability to conduct therapy, as they might feel that interventions are futile and therefore, cease or struggle to engage. The feeling that the relationship is *"not real"* could also impact the therapeutic relationship. Thus, working to form, or even maintaining a relationship could be viewed as meaningless. The client may also feel these attitudes and disengagement in the relationship and intervention alike may be seen.

Peter described an instance in which the therapeutic relationship did not feel disingenuous but rather impossible and hopeless as the client took pride in their crime, much like other participants had seen.

> *…it is **extremely difficult to remain neutral** when people are **callous** and give callous accounts of their lives with **no sense of guilt about it**. You can't just sit there and **just empathise because you don't want to** empathise, basically. Almost like, I'll give you an example. Some violent men, including sex offenders, actually **just enjoy talking about their offences**… and they actually get gratification from it… They would **then be futile**… there would be **no point in having a relationship.***
>
> *Peter, 3.402-3.411*

Here, Peter explains that empathising may not just be difficult but that there may be an active choice not to engage with it. For Peter, this is not the only factor that might disrupt the relationship; the sense of futility about attempting to build an alliance in these cases might be paramount. At first he suggests it may be *"extremely difficult"* and that *"you don't want to empathise"* suggesting it may be the practitioner's choice not to

engage because of the *"callous accounts"* shared by clients. However, soon after he gives an example of violent offenders taking pride in their crimes and that the work would then be *"futile"* placing the blame for the failing relationship back on the client and their nature. This suggests an interaction between practitioner and client in the possible futility of the relationship; in a sense, empathy may be difficult because of the presentation but this empathy may not even be attempted for the same reason. Moreover, Peter's switch from saying empathy would be just *"difficult"* to then saying it would be *"futile"* suggests a conflict within him, perhaps uncertain as to the potential for empathy. This could indicate, as Peter said, that practitioners might halt their pursuit of a therapeutic relationship, which could also negatively impact the possibility of carrying out any therapeutic interventions. However, the client's pride in their crimes may also imply that they may be unwilling to change or engage in any intervention that aimed at taking responsibility for their offence. In this case, interventions may indeed be *"futile"*.

In short, the participants seemed to share experiences driven by the understanding that endeavouring to build a therapeutic alliance could be *"futile"*, and thus, indirectly impacting the efficacy of treatment for psychopathy. It may also be that client's may feel this in that they might not want to change or may notice their therapist's pessimism and thus, disengage.

Subordinate Theme 3b: The Impossibility of "Genuine Internal Change"

Adding to the feelings of hopelessness present in the interviews, half of the participants suggested that genuine therapeutic change might be impossible for those with psychopathy and that those around them may have felt similarly, passing clients around from service to service.

Peter in particular discussed the generally pessimistic outcomes suggesting that those with psychopathy may only give up criminality because, over time, it was no

longer *"getting [them] anywhere"* (3.381). Furthermore, when discussing the possibility of therapeutic change being maintained in the community, Peter again suggested a type of futility.

> *...you are **not going to cure people**, literally suddenly cure people and **reverse their past propensities**. It is not very likely and, uh, the **research evidence suggests that as well.***
> *Peter, 3.134-3.138*

Repeating that one cannot *"cure people"* twice, Peter seems to emphasise again a sense of futility in the work. He goes further to use *"research evidence"* to support his claims, perhaps trying to legitimise the notion. However, Peter does appear to contradict himself slightly; first saying that you are *"not going to cure people"* and later, moving from an absolute certainty to a possibility saying, *"it is not very likely"* to cure people. This perhaps suggesting a conflict in Peter. Later in the interview, Peter even suggested that this population was best to be left in the *"Outback"* (3.162-3.163) which emphasises the hopelessness and even went on to elaborate that treatment could give people more skills, not unlike other participants beliefs.

> *[It may be that treatment] just gives people... **[smarter] strategies to manipulate** other people, you know?*
> *Peter, 3.212-3.214*

Peter appears to progress through the interview, continuing to draw attention to the significant issues that can arise in working with psychopathy. It seems as though Peter may not just believe psychopathy to be *"difficult"* and possibly *"futile"* but that treatment itself could make the manipulative aspect of psychopathy worse. With the use of *"you know",* it almost seems as though Peter would like the interviewer to agree with him or to recognise this assertion which appears to be quite important to him. This

could perhaps indicate a doubt. The sense of hopelessness that Peter describes could influence the treatment in that practitioners see no reason to begin or continue to engage in treatment because of the pessimistic outcomes. Moreover, if a client were to recognise that a practitioner had seen the work as futile, they may take pride in this, as with the label, but also, for those who would like to change, this could impact their sense of self worth and their belief in the effectiveness of therapy, possibly impacting future engagement in therapy.

Also implying that treatment aiming to generate therapeutic change might be difficult, Nina described situations in which individuals with psychopathy were only "managed" through their environments, attempting to curb violence on the ward and stop splitting within the team.

> *…but it felt more like* ***fire-fighting****, um so, it was more about how* ***we managed ourselves, how we managed the environment, the logistics****. It never really felt like* ***actual proper therapy****. So yes, I wouldn't say after* ***15 years in forensics*** *and* ***20 all told in mental health*** *I've come out with, "Actually, t****his is a great way to work with somebody*** *with this diagnosis."*
> ***I don't feel like that at all.***
> *Nina, 5.284-5.288*

Using the words, *"fire-fighting",* Nina's description brings to life a hopeless picture of damage control on the ward. It was as though the destruction of a *"fire"* may have already taken place and that, in reality, her role was about trying to ensure further destruction did not occur and not, as in other psychological work, to work therapeutically with her clients. Signifying her hopelessness, the sadness in the room was palpable as Nina described her work as not *"proper therapy"* and that, after all her years, she still did not have a way to work with psychopathy. Having to resort to using management techniques such as Nina describes could infer that no adequate treatments

exist for psychopathy and this could further impact a practitioner's feelings of hopelessness.

As the participants explained the hopelessness and sometimes, futility, of their therapeutic work with psychopathy, it appeared that they might be engaged in a constant battle with feelings of inadequacy. Perhaps this precarious area required a level of vigilance and reflection on the part of the practitioner in order to meet acceptable standards of progress and maintain their own safety, as well as to build the resilience to endure. However, these feelings could also have led to difficulties in continuing to engage with therapy, in building relationships with clients and even in finding reasons to begin treatment with an individual with psychopathy.

Subordinate Theme 3c: "Vigilance towards Myself"

Almost all the participants described gut feelings and instincts that they seemed to find themselves dependent on at times. Reflection seemed to be influential, informing decisions to continue or end work, reflecting on what feelings they might be bringing to the therapy and helping them to decide which approach to take with clients.

Melanie described a case in which reflection aided her decision to terminate therapy.

> *I think your **supervision** and **your own ability to reflect** is really important, um, in terms of how you **choose to engage or disengage with that relationship**. I think I can think of another case where ultimately, I just, I just **had to sort of withdraw**, it was a decision that was taken with **my supervisor at the time** with managers, that it had, uh, just reached a point where the individual concerned was so very, um**, angered and upset by so many things** that it just wasn't **tenable really to continue** to engage and really it was important at that point, to, um, **have other professionals come in** and try to engage with him and work with him.*
> *Melanie, 2.199-2.206*

Here, Melanie indicates that there might be a point wherein the relationship is not salvageable and, even, unsafe. Using the words *"choose"* and *"decision",* Melanie suggests that this may be an active choice on the part of the practitioner. There also appears to be a hesitation in naming the withdrawal by minimising it as a *"sort of"* withdrawal from the work, this perhaps indicating an uncertainty or insecurity in her decision. Additionally, she emphasises that vital to such a *"decision"* is the input of others in supervision as well as her *"own ability to reflect".* However, perhaps again indicating uncertainty or insecurity, she mentions three times the input of others in order to aid her in what may have been a difficult decision *("supervision", "with my supervisor", "other professionals").* It may be that this reaction or rejection can create a difficulty for the practitioner in engaging in work with psychopathy after this, because they may fear the same reaction. This might also trouble the client in that they may see therapy as ineffective or therapists as unable to understand them, impacting later interventions.

It appears as though using this reflection to question your own actions in therapy might also be useful. Below, Akbar spoke about an instance in which he had forgotten the first appointment with a client.

> *He said to me,* ***"You didn't come yesterday."*** *I said, "Oops, really? I'm really sorry." He said,* ***"You rejected me."*** *...I can remember coming back to my office and I said,* ***"Yes, he's right, maybe I'm consciously I-I don't want to work with him,"*** *so I* ***kind of rejected him*** *...then 3 months down the line he had a breakdown, he became psychotic and, and* ***I went through it with him so I was there.***
> *Akbar, 6.121-6.127*

In this instance, Akbar indicates that reflection proved to be very important. In his interview, Akbar freely spoke about the difficulties of working with psychopathy but

this was not without also speaking of the successes, as though he was showing that the work may be difficult but not impossible. In his work with a client which he initially did not *"want to work"* with, he was able to overcome this difficulty by acknowledging it, suggesting that owning the struggles in working with this type of presentation is vital (*"Yes, he's right, maybe I'm consciously, I-I don't want to work with him").* Akbar begins the statement above saying he *"maybe"* rejected his client but quickly switches to an absolute statement with *"I don't want to work with him"* before again hesitating to assert this rejection by describing it as a *"kind of"* rejection. This perhaps indicates a conflict within Akbar implying that he may be uncertain about his feelings at the time or even hesitant to share this experience with the interviewer. However, reflection further helped Akbar to own his own feelings so that Akbar could be present when his client had a breakdown, and to perhaps maintain a therapeutic alliance with him. This indicates that reflections such as this could unearth difficult feelings but that further engagement with these feelings may be integral to persisting through difficulties in treatment.

During her interview, Nina spoke often about how many of her colleagues would often express stigmatised and unhelpful views of psychopathy. Here, the view of one of the patients on the ward seemed to be quite the opposite.

> ***Every other patient bar him dropped out****, so the last* ***twelve sessions*** *were delivered to him* ***individually, with two facilitators****. It seems* ***bizarre****… I mean, why they didn't just stop the trial or find a* ***different way of running*** *that is* ***beyond me.***
> *Nina, 5.211-5.213*

Nina expresses confusion at this notion, describing her colleague's reactions as *"bizarre"* and *"beyond"* her, as though this was not a reaction she could fathom. Additionally, it may also be that, as Nina had expressed, this reaction to the client was

in complete opposition to the often negative reactions that her colleagues traditionally carried out leading Nina to be surprised and taken aback by this. Nina went on to explain that this particular client also received a leaving party upon discharge, which no other client had had. Nina seemed to promote reflection as important here in order to treat clients on the ward equally and fairly.

In short, the participants had substantial difficulties when building a therapeutic alliances and finding an appropriate approach to working with psychopathy. In this area of uncertainty, it seemed as though reflection proved to be an important tool to own one's feelings and not allow for it to impact the therapeutic work.

Superordinate Theme 4: Beyond "Hanging in There"

In considering the therapeutic approach, despite those participants who believed psychopathy to be untreatable, many of them discussed the models that they found helpful. Almost all of them promoted an individual approach, taking into account their client's PCL-R profiles and histories. However, it appeared that challenging clients was particularly unhelpful as two participants suggested.

Below, Akbar describes a case where he was able to build a relationship and achieve a positive outcome with a flexible psychoanalytic approach.

> *… And it **did work, therapy did work**; he did a **good piece of work**, he moved on, he **met another girl**, he is in a **relationship now**, he **went to college**, he **finished college**, so it kind of **progressed very slowly**.*
> *Akbar, 6.208-6.210*

Akbar repeats *"did work"* twice, going even further to say *"a good piece of work"*, emphasising the success of the therapy. Akbar goes on to evidence this by listing the areas that his client was able to successfully *"[move] on",* in a sense proving to the interviewer that the therapy *"did work"*. Considering his own difficult experiences in

treating psychopathy and the large evidence base suggesting the same, it may also be Akbar himself was surprised with this work, reiterating perhaps to himself whilst emphasising its success to the interviewer. Here, it may be that experiences like these could help practitioners continue through what might be challenging and enduring times in therapy and to also continue to work to build and maintain the therapeutic relationship.

Subordinate Theme 4a: Overcoming the "Troughs"

Many of the participants described ways in which they were able to overcome the difficulties of therapeutic work with those with psychopathy, with each focusing on unique aspects of their own practice.

Barry, although he recognised, as others had, that he would be doubtful of intentions in psychopathy for fear he was being *"groomed"*, he still felt as though his general therapeutic skills and an informed approach, based on his clients' PCL-R profiles, could help build this relationship and deliver his intervention.

> *…it is just the usual, um,* ***core rapport building skills*** *that one has as a psychologist,* ***taking an interest in someone****. Helping them to* ***not go in too fast*** *in the therapy. Not sitting down straight away and saying, "Right tell me about all your innermost emotions." Because I know he is* ***quite secretive and distrustful.*** *So taking it* ***slowly in building a relationship****, quite slowly, um, using you know all the tools that you have****. A bit of humour****, um, you know showing an* ***interest of aspects of himself outside of what he does just in psychology.*** *And then occasionally sort of taking someone a* ***bit more into areas where they feel more or less comfortable*** *and doing that in a* ***safe kind of way.***
>
> *Barry, 1.484-1.492*

Although Barry expressed the unique difficulties in treating psychopathy in his interview, here, he seemed to advocate a generalised approach. Barry seems to indicate that a relationship built outside of the therapeutic space may be vital *("helping them to not go in too fast in therapy"* and *"show an interest of aspects of himself outside of what he does just in psychology"*). He seems to support a relationship slowly built *"in a safe kind of way"* from an interest in the client which may establish a level of trust needed for exploration of *"areas where they feel more or less comfortable"*. Barry puts special emphasis on his clients *"secretive and distrustful"* nature as emphasised by the PCL-R and discusses the importance of paying attention to these individual features as you would with any presentation. Thus, showing that there are both generalised and individualised approaches to working with psychopathy. Barry's approach here suggests that treatment for psychopathy can be approached in a similar way to that of other presentations and thus, may not be as hopeless as previously suggested. Moreover, the PCL-R is yet again mentioned, possibly indicating that the profile may be a good means of judging which approaches to take to treatment and building the therapeutic approach alike.

In contrast to Barry's generalised approach, Melanie recognised the need for *"specialist"* programmes at times (2.94-2.96). However, also agreeing with Barry, Melanie spoke of the importance of building rapport and working with the individual.

> *…but thinking about **what their needs are**, what's **in it for them**, what **works for them**, what **motivates them**, what **drives them**… It's just a little bit **like all of us really, isn't it?** It's tapping into what are we **motivated by** and invariably it might be very **self-interested**, a great **focus on self** and perhaps stuff you might find in other people but **working with that, rather than against that** or trying to change things that you just can't change.*
>
> *Melanie, 2.156-2.160*

Here, Melanie, who had extensive experience with the PCL-R, which is able to capture individuality within the psychopathy presentation, emphasises a client centred approach. Repeating *"them"* four times, Melanie encourages practitioners to focus on their clients as individuals and find their motivations, interests, and needs, perhaps looking beyond what you might assume about psychopathy and paying closer attention to the individual. However, Melanie also indicates, in a sense, the generalisability of the approach saying, *"it's just a little bit like all of us really, isn't it?"*, bringing those with psychopathy into a space wherein they can be likened to those without the diagnosis. Much like Barry, it appears that Melanie finds the approach to psychopathy to be both generalisable and individualised. Later in her interview, Melanie goes on to explain how all of these factors can be linked to the *"Good Lives Model",* which helps her to work *"holistically"* with the individual (2.322-2.325). Similar to Melanie, Barry and Priya promoted an approach that focused on *"coping strategies"* (1.424-1.425) and management, possibly alluding to limitations and capacity. This generalisable approach implies that those with psychopathy might have similar needs to others, which may suggest a more positive outlook to therapy. It may also be that, with a focus on self-interest, this might help to build and maintain a therapeutic relationship.

Peter shared his take on working with the individual, where showing compassion and focusing on lived experience was vital to positive outcomes in therapy.

> *…Because generally people who enter the therapy industry are **compassionate** people but you can get **side-lined by all sorts of other agendas**, like a **model** or they get **burnt out or cynical**. So all sorts of things happen to them but their initial start point is maybe you can **understand people properly** if you just give **them enough time** and **we approach them***

in a way which says not what is wrong with you but what has happened to you?
Peter, 3.604-3.609

Not dissimilar to many of the participants approaches, Peter appears to promote where he feels therapy should start, with compassion, tolerance, and a focus on the client's unique, lived experience. Peter seems to suggest that practitioners can start at one end of a spectrum with compassion but that rigidity in *"models"* and *"agendas"* can lead them to find themselves on the other end of this spectrum, becoming *"burnt out or cynical"*. Interestingly enough and in conflict to previous statements, Peter is not using client presentation to explain the difficulties inherent in work with psychopathy but rather, putting the onus on the part of the practitioner. Peter may also advocate a patient approach, similar to that of Barry, suggesting that it takes time and a calm demeanour to build the relationship necessary for therapeutic work ("*maybe you can understand people properly if you just give them enough time")*. As a majority of the patients discussed how many with psychopathy seemed to have *"biographies which are quite brutalising"* (Peter, 2.85), this may be particularly important. It appears taking a step away from pathology and focusing on building a relationship through understanding is vital to working with psychopathy and this might illicit positive reactions from the client. However, if working from a compassionate and forgiving perspective is really at the core of therapeutic work, it may be that this cynicism and fatigue could break down the therapeutic space and lead to ineffective work

Moreover, half of the participants also indicated that therapy with those with psychopathy was a long-term investment.

…but again it's ***gearing yourself up for that sort of investment****, I think can be* ***quite hard*** *and* ***knowing how many years' worth of work*** *is going to go into something.*

Nina, 5.195-5.197

Nina explains how work will span a number of years, stating it as an *"investment"*. However, the use of the word *"investment"* may indeed imply that there is hope in the work, as though the work is an asset of some kind that may pay off in the long run. Additionally, the use of the phrase *"gearing yourself up"* creates a depiction of a practitioner mentally and physically preparing, possibly for what Priya had earlier described as a *"hard slog"*. It may be that here, a vigilant approach may be vital to continued work.

In considering specific models, Akbar promoted working with the individual in a psychoanalytic way.

> *...you need to be* ***flexible and elective*** *what kind of approach... I think it depends on* ***the therapist*** *as well,* ***how much experience you have and how do you deal with hatred*** *and what do you do with it – is it disturbing or is it something you can work with?*
>
> *Akbar, 6.342-6.346*

Akbar explains how being *"flexible",* much like the other participants had shared, was quite important. He also makes use of the work *"elective",* implying a power and expertise in the ability to choose what approach to use with a client; a privilege bestowed on the practitioner and informed by the client. Here, working with *"hatred"* seems to be an important concept to be aware of and to help practitioners to manage the challenges of therapy. Posing this in the form of a question, as he had quite frequently throughout the interview, it suggests that this is a question that practitioners should pose to themselves in this area of work and that perhaps Akbar, in his reflections, had posed

to himself. However, this awareness might also contribute to feelings of hopelessness, because the idea that you might hate your client could be quite difficult to tolerate, and even more difficult to see in practice.

Apart from psychoanalysis, Nina in particular found that schema modes were the only intervention that she had found to be *"useful"*.

> *It seemed to be **useful** to have them think about **different schema modes**, particularly the **forensic modes**, and, and, that was because they were having some difficulties on the ward...*
> *Nina, 5.311-5.313*

Thus, approaches such as psychoanalysis and schemas could be helpful guides to working with psychopathy and provide structure in an uncertain field. Here, schema modes also seem to help with *"difficulties on the ward"* suggesting that the insight gained from schema therapy could be applied and used in the patient's current environment.

In short, the practitioners seemed to have their own unique approaches but there was also an overlap. These approaches appeared to be able to provide structure and containment, while promoting flexibility that would enable practitioners to work with the individual and not purely the diagnosis.

Subordinate Theme 4b: Nothing to do with Therapy

Outside of approaches, most of the participants found that certain environmental factors such as relationships, children, employment, redirecting aggression and religion could positively impact therapeutic outcomes.

During his interview, Peter shared what he found helpful.

…it is just whether they are going to form straightforward ***real relationships.*** *Not therapy relationships,* ***relationships with peers****… You* ***might be able to facilitate it****. And another example of that facilitation by the way, is* ***finding God.***

Peter, 3.229-3.236

Here, repeating *"relationships"* three times, Peter seems to support the notion that forming relationships might be essential to positive outcomes. He suggests that the therapeutic relationship is not necessarily a *"real"* relationship, as though it's a false or pseudo relationship and its impact may be quite small or insignificant. Peter emphasises the importance of clients to be able to form relationships outside of therapy with their peers or even God. Peter indicates that as a practitioner, the role is to help initiate or *"facilitate"* this but, in the end, it is these more genuine relationships outside of therapy that will make a real difference. The importance of these external factors could be important, because if therapy is found to be generally challenging or ineffective, these factors might support both the client and the practitioner. Moreover, these factors could also complement therapeutic interventions, allowing both the client and the practitioner to see improvement.

Melanie also recognised that relationships were important. She noted that the therapeutic relationship and employment was key but also reflected on a positive outcome she had with a client whose partner was heavily involved in the treatment.

There is ***increasingly a focus on factors outside of interventions*** *that are significant in* ***helping people to move away from offending lifestyles****, um, and I think it's* ***really helpful****, actually, that an* ***increasing amount of weight*** *is being attached to that, in terms of treatment reports and considering treatment outcomes. You know,* ***we know that programmes aren't the be all and end all and why would they be?***

Melanie, 2.357-2.362

Melanie depicts a, perhaps recent, shift in the field with an *"increasing… focus on factors outside treatment"*, suggesting that practitioners and researchers alike may be seeing what she had witnessed: that therapy is not the *"be all end all"* of psychological progression. Melanie's comments indicate that the poor treatment outcomes in psychopathy are too narrowly focused on therapeutic approaches, without due consideration of environmental factors. This change in focus might help practitioners to recognise client's external relationships, providing a systemic view and, in turn, helping to generate more positive outcomes. Moreover, as mentioned above, this may be particularly important for those clients rehabilitation that are not responding to therapeutic interventions.

It appears that the impact of external factors might provide some support for clients and practitioners alike, allowing them to maintain the resilience needed to continue therapy. Moreover, these factors might positively impact treatment outcomes.

Subordinate Theme 4c: "Challenging Them"

Despite the impact of external factors, two participants in particular mentioned a factor that they felt was unhelpful to the process of therapy. Melanie explained that challenging her clients was particularly unhelpful.

> ***Challenging them*** *[laughs]. Some could deliver any number of responses, depending on what you're challenging them with and, and actually their presentation, um, whether they felt that* ***you were making attempts to undermine them,*** *whether they* ***were affronted by it****. I remember interviewing one chap and he'd given me a* ***completely fictitious life history*** *and when I returned to talk, talk it through with him and just explore how that fit with files about him, he just* ***started reworking his story*** *and it was just* ***really remarkable actually…***

Melanie, 2.277-2.282

Here, Melanie describes how ineffective challenging was despite earlier in her interview, having stressed the importance of client's being receptive to feedback (2.183). When asked if she had found anything unhelpful in her practice, Melanie almost immediately answered with *"challenging them"*, as though this were an experience at the forefront of her mind. Melanie seems to acknowledge the diversity of *"responses"* she could get again emphasising the unique presentation of each individual. However, she also describes how *"remarkable"* her client's reaction was, as though she had never witnessed such a shocking *"reworking"* of a client's story; this perhaps pointing to the uniqueness of the experience. This could create a difficulty as it might not be practical to avoid challenging because this might be integral to many therapeutic interventions. Thus, this could limit the amount of possible interventions but also, lead to interventions being delivered inadequately. It may also be that holding back challenging may create apprehension on the part of the practitioner that may be noticeable to the client as a disingenuous nature and thus, impact the therapeutic relationship.

Similarly, Akbar found that confronting one of his client's with his own aggression was unhelpful.

> *With the other one, I don't know, maybe he made some progress I have no idea, but* ***I felt like I had to end it*** *because he was quite, he used to text me a lot and there were times* ***when I felt threatened by him*** *and* ***you have to be safe too****. And every time I put it back to him, "Look, you're threatening me."* ***Complete denial,*** *like kind of, "That's not my intention. I don't know why you're making a big fuss out of it." And I'd think,* ***"For God's sake you're threatening to kill me."***
> *Akbar, 6.210-6.215*

Akbar's hopelessness again was quite discernible in this excerpt. Having felt *"threatened"* by his client who had completely denied his actions, Akbar appeared helpless in the work. Akbar shares that he directly pointed out to his client that he was *"threatening him"* but says that there was very little acknowledgement and that the client had actually down played it, as though Akbar has overreacted. Here, it seemed as though Akbar had been, in a sense, let down and even confused by his client's actions and the work itself, with *"no idea"* as to whether or not his client had actually *"made some progress";* this bringing to life the hopeless nature of some of Akbar's work with psychopathy.

The denial that Akbar described could create a difficulty in building a trusting relationship with the practitioner. The practitioner might be afraid for his or her safety, thus, impeding the relationship that could impact the intervention being delivered effectively, as seen in Akbar's example. Moreover, this could lead to a termination of therapy, as other participants have discussed.

Chapter 4: Discussion

The chapter will comprise a discussion of the findings of this study, how it relates to current research and what new or unique aspects it adds. The implications of the current research will be discussed for both the field of psychology and psychopathy and the wider community.

Summary of Main Findings

As noted in each interview, the label "psychopathy" or "psychopath" has immense power, both as a damning label and badge of honour. Certain participants had experienced fear at the diagnosis or had witnessed their colleagues using the term in prejudiced and unhelpful ways. This aspect of the current study appeared to be consistent with previous research findings as individuals with the diagnoses have been seen as almost inhuman, has long been present in literature and in practice since Cleckley first coined the term in 1941. In contrast, certain participants had encountered clients who took pride in their label and the apparent status it could provide in their forensic institutions. According to Hare (2003), this is not surprising, because individuals who display traits and behaviours of psychopathy are known to take pride in their crimes, as well as in their belief in their own superiority, which this study seemed to support. Lending further support to this notion, this study was not unique in that respect.

However, in considering the power that the label seems to hold, some participants in this study seemed to suggest that an assessment to formally diagnosis psychopathy was not always necessary. They explained that the diagnosis might contain distinguishing features that could be felt in the room, deeming the assessment unnecessary. Participants equally recognised that colleagues had practiced this as well, assigning the label without a formal diagnosis. Moreover, a level of concern was

described in that one participant believed that a formal assessment and diagnosis could impose an enduring stigma, which would be unhelpful throughout the client's life.

As the participants argued, the characteristics of psychopathy could present themselves in unique, subjective ways. Many of them appeared to recognise a level of heterogeneity, with many of them arguing that no two presentations were the same, despite having similar scores on the PCL-R. Moreover, all of the participants seemed to suggest a type of continuum, meaning that some individuals who did not score on the PCL-R still might have traits and behaviours of psychopathy. This argument that psychopathy lies on a continuum is congruent with Hare's (2003) PCL-R, as well as the current research in mental health, in which mental health diagnoses are seen to lie on a spectrum (Craddock & Owen, 2018).

The participants also shared that working with psychopathy brought with it feelings of insecurity, hopelessness and uncertainty. In particular, they described aspects of the therapeutic relationship and the therapeutic work that led them to feel deskilled as practitioners and hopeless concerning outcomes. More specifically, they found that empathising with particularly callous clients was difficult and that some clients could act in threatening ways, leading to the breakdown of relationships. Additionally, they found that poor treatment outcomes and hitting *"dead"* ends led to a sense of futility. Consistent with poor treatment outcomes, as well as challenging depictions of the therapeutic alliance, this study further supports current research (Thornton & Blud, 2007; Martin, Garske, & Davis, 2000;).

However, the participants also noted the importance of reflection in working with those with psychopathy. As they explained, it helped them to maintain high standards of practice, owning their feelings and helping them to continue their work. Moreover, these reflections help them to pinpoint their client's needs, through the transference, and to tailor their practice to their client. Although reflective practice has

been shown to be important in psychology, it appears it has not been extensively discussed within psychopathy literature (British Psychological Society, 2017).

More specifically, the participants suggested that their practice was informed by client's unique needs, whether this be from comorbid disorders, their client's subjective experience, or even their client's varying PCL-R profiles. Many participants shared that their idiographic stance to treatment could be generalised to their other clients, which seemed to imply that no single intervention was more useful than another and that the approach needed to be tailored to their client. It appeared that parts of this were consistent with current research on interventions and in accordance with the results of two client experience studies, which found that clients with psychopathy desired an individualised approach to their treatment (Tew, Bennett, & Dixon, 2016; Durbeej, Alm, & Gumpert, 2014).

Moreover, many of the participants discussed the importance of external factors, such as religion and relationships, which appears to be missing in the psychopathy literature, in which only criminogenic needs are mentioned (Zagożdżon & Wrotkowska, 2017; Braithwaite & Holt-Lunstad, 2017; Wong & Burt, 2007). The participants in this study suggested that these external factors could be important to treatment outcomes, especially when treatment was ineffective or challenging. Interestingly, it appears that the current literature might be, in part, in conflict with the need for relationships, because it has been argued that those with psychopathy might be unwilling or uninterested in forming relationships (Hare, 2003; Williams & Simms, 2016).

Contextualising Findings in Research

In this study, there seemed to be an undercurrent of violence, with practitioners mentioning a level of risk or dangerousness. With some, clients had threatened them directly, with others, the clients had hurt others in the community and on the wards in

purposeful violent acts, and sometimes, their clients felt quite proud. The association of psychopathy and violence does seem to have support in literature which has shown that those with traits and behaviours of psychopathy have higher rates of crime, including violent crime, and are less likely to desist from crime (Kiehl & Hoffman, 2011; Theodorakis, 2013). It may be that this association might cause fear on the part of the practitioner and cause apprehension or a preoccupation with their own safety. This, in turn, may distract from building a therapeutic relationship and carrying out therapeutic interventions. As one participant pointed out, having a containing environment within a prison allowed him to feel safe, possibly speaking to the importance of having an adequately safe setting so that the practitioner may focus on their client and the therapeutic work.

Despite this association between risk and psychopathy, some researchers have argued that "myths" around psychopathy might also be at fault for this. Skeem et. al (2011) argued that there are indeed myths equating psychopathy and violence and that these might give rise to faulty assumptions of their violence risk. In this study, it was also suggested by participants that the correlation between violence and psychopathy could be equally correlated with other individuals within the forensic system. In accord with this, it has also been shown that psychopathy is no more effective at predicting violence than a past history of violence (Skeem et. al, 2011). This suggests that there might be a need for more education on the subject throughout the community and even within the psychological community itself. It may be that this could help practitioners to focus on their therapeutic relationship and work, whilst not being preoccupied with a client's risk. However, it must be said that this conflict amongst professionals may pose a concern. If certain professionals wish to focus on risk because of this association, a focus on alternative topics, possibly their biographies or subjective needs, may be ignored and lead to inappropriate or unhelpful interventions.

Many of the participants had also observed that their client's had recognised the stigma associated with their diagnosis. The participants shared that client's felt their diagnosis might be used in a negative way, perhaps to deprive them of their release or from certain treatments. This notion may not be completely unfounded. Within psychopathy literature it has been suggested that, in the legal system, the term "psychopath" does indeed have a damning connotation and is often used as a "synonym for incorrigible" (Kiehl & Hoffman, 2011). Additionally, it has been shown that a diagnosis of psychopathy can lead to exclusion from certain treatment programmes (Wong & Olver, 2015). More specifically, those with psychopathy may be excluded from therapeutic communities because of disruptive behaviour or may be deprived of other treatments because of the belief that it will be ineffective or make the individual worse (Wynn, Høiseth, & Pettersen, 2012). However, although some clients and researchers alike have suggested that the label might impact release dates, research has shown quite the opposite, indicating that those with a diagnosis of psychopathy are more likely to be granted conditional release (Filone, Strohmaier, Murphy, & DeMatteo, 2013; Porter, Brinke, & Wilson, 2009).

Despite this conflict, as was seen in the findings, the perception that these individuals may be deprived of these rights instigated an angry response in some clients, which may further perpetuate the idea that psychopathy and violence may be related. In knowing the presentation of traits and behaviours of psychopathy, it might be difficult for client's to manage their feelings, especially when being treated differentially or perhaps unfairly. It may be that trying to understand the distress behind the reaction, rather than focusing on the violent reaction itself, may be helpful at providing clues for how to best manage these situations but also, how to best inform whether or not excluding those with psychopathy from treatments is useful or even, fair.

It also appeared that these powerful perceptions of psychopathy influenced the

decision to use an assessment such as the PCL-R. A number of participants alluded to the fact that characteristics of psychopathy were so distinctive that they could be felt in the room, deeming the assessment unnecessary. Moreover, one of the participants feared diagnosing the individual would be unhelpful, leading the diagnosis to be used as *"shorthand"* that would follow them around. Despite this, one participant pointed out that the shorthand of *"psychopath"* was used regardless of an assessment and that she found it to be unhelpful and stigmatising. It may be that in cases such as these, neglecting the assessment may lead people to assign the label to those they find challenging or "incorrigible" (Kiehl & Hoffman, 2011) and create false perceptions of psychopathy. This in turn, may lead to the application of unhelpful treatments to those without psychopathy. Moreover, this may also lead to the establishment of treatments that may treat certain characteristics of psychopathy but not diagnosable psychopathy.

The lack of assessment poses another concern as well. As almost all of the participants suggested that PCL-R profiles helped them to tailor their approach to the individual, it does seem as though it is a valuable tool which was neglected. This does create the concern that, without a PCL-R profile, it may be that practitioners are not able to as accurately tailor their approach to their client and work with their motivations, strengths and limitations that may be evidenced in their assessment.

In contrast to these negative perceptions, other participants described the label as a *"badge of honour".* The participants explained that the antisocial nature of the label was able to give their clients status in their facilities and that many of them wore this proudly. This observation seems to be supported by research in a number of ways. Firstly, the facets of grandiosity within Factor 1 could suggest that these individuals would seek status within their institutions, which the diagnosis may be able to provide (Hemphill & Hart, 2002). Moreover, Hare's (2003) PCL-R explains that this grandiosity puts those with psychopathy in a position of power, and that they may believe that they

are superior to those without psychopathy. This might explain their pride in having such an influential label.

However, within forensic settings, especially prisons, the environment seems to be characterised by patterns of masculinity and this might influence these perceptions of the label. Research has been conducted on what has been called the “prison macho” (Hua-fu, 2005). This is defined by actions such as hiding vulnerability, hiding fear and pain, refraining from assisting authorities, being generally mistrustful of others intentions, and being prepared for physical conflict at any moment (Sabo, Kupers, & London, 2001). Considering these beliefs, Factors on the PCL-R seem to share similarities with this culture and embodying these characteristics within psychopathy might help to elevate a prisoner’s status. Thus, a client study might be useful to consider what motivations these individuals have to wear their label as honourable and whether or not it may have to do with the forensic environment. It should be considered that hyper masculinity may be a façade adopted for the prison environment and thus, clients might be able to adapt their outlook in private settings such as a therapy room and even in the community. In this case, a trusting therapeutic relationship could help clients to express their vulnerabilities in therapy.

However, clients being genuinely proud of this label of it’s antisocial nature may not embody adequate motivation to change in that they may feel that they do not need to or do not want to change. As one participant mentioned, it is *“we”* (practitioners and society) who want them to change, maybe to the extent that one study in particular found that clients felt pressured into treatment (Durbeej, Alm, & Gumpert, 2014). It may be that this pressure could impact the therapeutic alliance. Moreover, this lack of motivation could also lead the practitioner to operate under the assumption that the client does not want to change and thus, not actively engage in therapy or in building and maintaining the therapeutic relationship. In contrast to this, in research it

has been shown that this need for status within psychopathy could be helpful in treatment. For example, researchers have suggested that highlighting that committing offences as "low status" might help to create a motivation for change (Harris, Attrill, & Bush, 2005).

As mentioned above, client motivations for wearing this label with pride may be important. More specifically, as one participant noted, the power associated with this label also sets them apart from those who have been diagnosed with mental health conditions because the stigma associated with psychopathy is less and more powerful. This might indicate a type of alienation or prejudice associated with mental illness that is, in a way, more adverse than that associated with psychopathy. Thus, despite the stigma, the high status of psychopathy is favoured over the implied powerlessness or weakness of mental health. However, this would be difficult to ascertain without further exploration. This status might support the notion that a particular client might be unwilling to change, which will negatively impact the relationship and interventions. Moreover, if poor mental health is seen as a weakness, the client might, in turn, view any intervention to address this as an indication of that weakness and thus, disengage from therapy.

Many of the participants in this study agreed that, regardless of the perception of psychopathy, the diagnosis lay on a spectrum. One of the participants in this study, much like current researchers, argued that Hare's (2003) model allows for psychopathy to fit into the type of spectrum or continuum that they described, because of the different Factors (1 and 2) and how the facets of these Factors were rated on strength, from 0 to 2. Participants shared that clients could exhibit varying degrees of interpersonal and behavioural characteristics of psychopathy and thus, no two presentations were alike. Some explained that scores alone on the PCL-R could not tell how a particular client would present, arguing that Factor 1 or Factor 2 loading was

most important and helpful for tailoring the therapeutic approach. However, others argued that the severity of the score (low to high) could also be a distinguishing factor and that this number was an aspect upon which their practice could be based. It seemed that within both these groups, both Factor 1 loading individuals and those with high scores were considered to be more difficult to treat and possibly, untreatable.

This heterogeneity and recognition of the difficulties in treating those with Factor 1 loading or higher scores can be seen in the psychopathy literature, especially in reference to treatment needs and outcomes. For instance, those individuals who score high on the affective items of Factor 1 might not benefit from treatments that try to increase their empathy. But conversely, it is believed that those scoring on Factor 2 may find this treatment helpful (Thornton & Blud, 2007). Durbeej, Alm, and Gumpert (2014) found that higher levels of psychopathy in individuals made treatment more complex with low engagement from clients driven by a lack of willingness to change and a lack of confidence in the treatment. Similarly, Martin, Garske, & Davis (2000) found that forming attachments was particularly difficult for those with higher Factor 1 scores which may complicate an integral part of therapeutic interventions, the therapeutic relationship. These complex needs were also reflected in the participants' responses, with some pointing out the difficulty these individuals had with engaging in mainstream programmes and others describing the unique ways in which they would have to then approach treatment, considering their motivations, limitations and strengths, heavily based on their PCL-R profiles and personal histories.

Thus, it is apparent in previous research and in this study that there are distinguishing factors between the level of psychopathy, as well as Factor loading, which should be considered when approaching treatment and the therapeutic relationship. However, assumptions based on scores and Factor loading could create pessimism when approaching treatment and thus, create a difficulty in approaching

treatment and engaging in the therapeutic relationship. Moreover, clients who are aware of the reputation that Factor 1 or high scores have may themselves be pessimistic of outcomes and, as stated in research, have little confidence in treatment's ability to change their behaviour (Durbeej, Alm, & Gumpert, 2014). This may result in a lack of engagement from the client as well, negatively impacting the therapeutic relationship and treatment outcomes alike.

In recognising the heterogeneity of the population, some participants also noticed the similarities between antisocial personality disorder (ASPD) and psychopathy. The participants shared comparisons within their institutions between the two and how, often times, those with ASPD may be confused with having psychopathy. This may be due to Factor 2's traits being largely based on the disorder. Karpman (1941) in particular has argued that the traits present in Factor 2, the behavioural aspect, are not representative of psychopathy and that only Factor 1 characteristics, the interpersonal aspect, represent "true" psychopathy. It seems that Cooke and Michie (2001) recognised this conflict as well and thus, created a three-factor model, in which they removed the PCL-R items associated with ASPD because they believed them to be symptoms of psychopathy rather than a feature of the diagnosis. Despite this, none of the participants mentioned any awareness of this model, which might support the observation that PCL-R is the dominant assessment tool in the field. However, a lack of recognition for this hypothesis may continue to maintain this blurring of the aspects of psychopathy and ASPD which may again, lead to false perceptions of psychopathy and unhelpful interventions being established to address trait level but not diagnosable psychopathy. Also, as mentioned before, this may also deprive a person with ASPD of interventions that may be useful for them if they were to be excluded from certain treatments that those with psychopathy are sometimes denied access to.

Moreover, in considering the diversity of this population, the limitations of The

Dark Triad (DT) should be mentioned. In contrast to participant observations, DT seems to indicate a homogeneous population within psychopathy. Despite research showing that individual's relationships to certain traits present in the triad have shown to be unique, the literature around the triad appears to remain the same (Jonason, Lie & Buss, 2010; Jones & Paulhus, 2011). Therefore, this study may support the criticisms of DT and suggest that the population is indeed heterogeneous.

Nonetheless, many of the participants recognised that this spectrum could also imply that traits and behaviours of psychopathy are present throughout the population. Most of the participants applied traits and behaviours of psychopathy to the idea of the "successful psychopath", claiming that these individuals operate in society, holding roles in business, running universities, NHS trusts, and even taking part in politics. Despite the fact that most of the research in psychopathy is concerned with those who have committed crimes, many researchers have agreed with these participants and argued that there are individuals with psychopathy leading what could be seen as normative lives within the community (Listwan, Piquero, & Van Voorhis, 2010). Despite one participant's belief that the PCL-R could capture this end of the spectrum, some researchers have argued that because of the way assessments are structured and the multidimensional continuum upon which they are based presents difficulties in establishing a "clinical disorder" (Chiaburu, Muñoz, & Gardner, 2013). It is believed by some researchers that individuals have to score extraordinarily high on this spectrum to be deemed a "psychopath" in the forensic sense, thus, causing difficulties in assessing and identifying the concept of a "successful psychopath" (Levenson et al., 1995; Neumann & Hare, 2008). Moreover, research which points to the normalcy of embodying these traits may have important implications for the field.

One participant in particular suggested that individuals who are successful, in a sense, fly under the radar and go unnoticed. It could be that these individuals could be

the living embodiments of the “Mask of Sanity” that Cleckley first posited in 1941 and may change the idea that this ruse they engage with is purely to do evil. However, some researchers have argued that what allows those with psychopathy to appear “successful” at work is rather an illusion of success at the expense of honest work (Babiak & Hare, 2006; Stevens et al., 2012). This perhaps indicating that psychopathy in the workplace may need further examination to understand how these individuals become successful, perhaps shedding light on what features therapeutic interventions could foster.

However, other researchers have taken this a step further, arguing that it might not be a mask of sanity at all and that those individuals who are successful could have had distinctive experiences and characteristics that set them apart from their “unsuccessful” counterparts. Lykken (1995) suggested that pride could help protect those with traits and behaviours of psychopathy from indulging in antisocial behaviour. It is believed that warm parenting and other socialising agents might promote alternative means of socialisation and might also promote pride as a protective factor against antisocial behaviour, as in the research of Costello, Unterberger, Watts & Lilienfeld (2018). More recent research has argued that psychopathy and altruism lie at opposite sides of the selfish-selfishness spectrum and are both governed by rewards systems (Sonne & Gash, 2018). The authors argue that strong positive parenting or even compassion training may modify genes associated with social disorders defined by callous, unemotional traits. The researchers were able to take this further by promoting positive behaviour through the brain reward system may provide a unique approach to reducing violent and destructive behaviours (Sonne & Gash, 2018). Thus, it may be that the participants in this study have lent support to the importance of studying the “successful psychopath” and that, as explained in the above research, compassion focussed treatment that may provide opportunities for rewards may be useful in treatment for psychopathy.

Further to this, as one of the participants argued, there may be a social utility of traits and behaviours of psychopathy. One participant in particular commented that psychopathy might have been needed at a time in society when it was necessary to battle against the *"neighbouring tribe",* as he explained. It was found that Lykken (1995), quite similarly to this particular participant, described heroism and psychopathy as two sides of the same coin. More recently Smith and Lilienfeld (2017) were able to show that Fearless Dominance and Boldness were present both in heroism and in psychopathy. Research such as this might suggest that psychopathy itself does not unequivocally result in violence and that, certain traits and behaviours of psychopathy may be redirected into pro-social ways, providing valuable insight into the area of treatment for psychopathy. However, it must be said that the research suggesting ideas about the successful psychopath (as stated above) have come primarily from studies which use university students with traits of psychopathy rather than diagnosable psychopathy. Thus, this may create an issue of generalisability and research would need to be done on those with diagnosed psychopathy.

Despite the silver lining that the "successful psychopath" may provide, during the interviews, it appeared as though all of the participants experienced challenges in building relationships with and treating their clients with psychopathy. Specifically, half the participants suggested that psychopathy might be untreatable and that the work was *"futile".* Although many of them based these notions on their own experience, it must be considered that part of these perceptions may be, as Salekin (2002) and Sörman et al. (2014) have pointed, due to a "therapeutic pessimism" present in the field, fuelled by myths, possibly impacting the development of new, effective interventions. Moreover, a review of 24 treatment studies in 2004 showed that there was no evidence to suggest that psychopathy was untreatable (D'Silva, Duggan, and McCarthy, 2004). Thus, this creates a question around practitioner perceptions of treatments and whether or not the

participants in this study who suggested that psychopathy was untreatable were outliers. In considering the fact that many of the participants discussed the issue of *"capacity"* it may also be that clients are limited in the outcomes that they can achieve. Thus, it may be that therapist's expectations may be too high or inappropriate for this population.

Contributing to this pessimism, some participants suggested that treatment might make the individuals worse; some believed that treatment could give them better strategies to manipulate others and to, in some ways, become more skilled at the behaviours already present within psychopathy. The current literature does not support this notion. While researchers have agreed that the wrong types of treatment might lead to disruptive behaviour, acting, pushing boundaries and even a struggle to remain in treatment, there is no evidence to suggest that the condition is either untreatable or that any intervention will make them worse (Hobson, Shine, & Roberts, 2000; Thornton & Blud, 2007). It is possible that negative experiences could have indicated that the clients were in therapy not directly suited to them; thus this behaviour might have appeared to support the notion that psychopathy is untreatable or that it makes clients worse. This again indicates that more research into therapeutic interventions and greater awareness in the field is necessary.

Moreover, many of the participants also shared a difficulty in building therapeutic relationships. Specifically, they explained that attempts to empathise with their client's callous accounts of crimes and to tolerate the hatred they felt towards their clients were trying. This might be problematic for the treatment of psychopathy because wider research in the area of psychology has shown that the therapeutic relationship is the biggest determinant of change in therapy (Duncan, Miller, Wampold & Hubble, 2010).

In contrast to the participants' experience, research has shown that it may be possible to build this alliance and that those imprisoned who are able to increase the

strength of this relationship over the course of treatment tended to exhibit the most therapeutic change (Polaschek & Ross, 2010). Moreover, researchers have also shown that clients with psychopathy did wish to form relationships with their therapists (Tew, Bennett & Dixon, 2016). If it is indeed true that these relationships are not only important but also possible, this begs the question as to what factors help to build therapeutic relationships in work with psychopathy and how best to apply them.

In 2001, Ackerman and Hilsenroth (2001) investigated what aspects of a therapist contributed to poor therapeutic alliances and they found that characteristics such as being distant, tense, critical, uncertain or distracted would negatively impact the alliance. Many of the participants' apprehension and doubtfulness of their client's motivation, for fear they were being groomed or threatened, may create a distant, uncertain and tense atmosphere. Moreover, a preoccupation with violence risk might also create this atmosphere as well as cause the practitioner to be distracted. Ackerman and Hilsenroth (2003) also investigated what positively impacted the relationship and found that an honest, flexible, respectful, confident, warm, interested, and open therapist could facilitate a strong relationship. They found that techniques such as facilitating expressions of affect, attending to the clients' experience, exploration and reflection were also effective. It appears as though almost all of the participants promoted a flexible attitude, attending to the client's subjective experience, and that some, even promoted a compassionate approach. However, based on the prison environment and the characteristics of psychopathy, it may not always be possible for the individual to be open or to express affect. Moreover, preoccupation with violence risk or doubting their client's motivations may distract from the warm, confident, and open nature that is needed to facilitate this relationship. Thus, it seems that there may be many key attributes in the work that may hinder the therapeutic relationship. Despite the apparent struggles that many practitioners may face in building these relationships, there seems

to be little guidance of how to overcome these *"troughs"*. It may be that further literature that could contribute to methods of how to best build these alliances and how to manage a difficulty in empathy with those with psychopathy. Thus, further research on this topic with a view to adequately supporting practitioners is needed.

Furthermore, almost all the participants indicated that this uncertainty and pessimism seemed to require a substantial level of reflection. The participants shared that this reflexivity presented itself in order to confirm that the therapeutic relationships had broken down to the point that interventions or assessments needed to end. Moreover, other participants affirmed that this was an important way of assessing countertransference and transference, learning which reactions and feelings were theirs and which were their clients. Perhaps most notably, two participants shared how this reflection was vital to understanding their motivations for certain clinical choices. For example, one described how he had forgotten a session with his client and how this reflection allowed him to see that he might be rejecting his client. Although researchers in the field of psychology have indicated the importance of reflective practice, within the literature on treatment for psychopathy, there seems to be little research that promotes a reflective approach as fundamental to therapeutic work (British Psychological Society, 2017).

This vigilant approach did not seem to be the only tactic used in working with psychopath. In this study, many of the participants described approaches that they found helpful. It seemed that considering the unique aspects of client's PCL-R profiles might be helpful and certain participants indicated that this was the basis from which they formulated their approach. For example, some participants indicated that taking into account a "secretive" nature could inform the pace of their interventions. This meant they could take a more delicate approach, not pushing the client to enter into uncomfortable territory before rapport was built. This has been supported in research

that has shown that taking into account the severity of the score on the PCL-R and Factor loading both can have important implications for treatment outcomes. More specifically, considering an individual's capacity for change, as well as their strengths or weaknesses, seemed important. Some participants suggested that attempting to change aspects of a person that were not changeable should be avoided and that, when possible, the practitioner should look at the client's strengths and target these in treatment. In research, it has been suggested that for those with high scores on the affective items of Factor 1, it might not be effective to attempt to increase empathy because it may not be within their capacity, but those who score lower on these same items might respond well to this type of treatment. Moreover, Craig, Dixon and Gannon (2013) further suggested that finding and catering to a client's strengths might be key to positive treatment outcomes for psychopathy and also provide an opportunity for positive reinforcement.

Further to working with the individual, participants indicated that considering self-interests and motivations of their clients was important. This theory is in accord with current research. Studies have indicated that tailoring therapeutic approaches to the individual might be useful. For example, for those who exhibit a desire for control, it may be helpful to engage in treatment that allows them choices and encourages them to take responsibility for their actions (Harris, Attrill, & Bush, 2005).

Comorbidity was also a factor that was considered by the participants. Some of them recognised the presence of other mental health conditions and how these might impact their presentation. Within psychopathy research, this is said to be an important area that might be little understood (Blackburn, Logan, Donnelly, & Renwick, 2003; Nioche, Pham, Ducro, de Beaurepaire, Chudzik, Courtois, & Réveillère, 2010; Stâlenheim & Von Knorring, 1996). For example, it has been shown that 23% of a prison population with mental health disorders also had psychopathy (Blackburn,

Logan, Donnelly, & Renwick, 2003). Comorbid disorders have been shown to be antisocial, histrionic, narcissistic, and borderline personality disorders, as well as substance misuse (Nioche, Pham, Ducro, de Beaurepaire, Chudzik, Courtois, & Réveillère, 2010; Stâlenheim & von Knorring, 1996). This implies that comorbidity might be common and diverse, which indicates that more research into the topic is vital but also that a single approach might not be effective when working with both comorbidity and psychopathy.

Furthermore, a compassionate approach was promoted by some of the participants. One participant implied that compassion was fundamental to all psychological work, with another suggesting that practitioners should respect individuality and that these were integral to positive outcomes. Interestingly, two qualitative studies on treatment for psychopathy found that client's were asking for just that – respect and an approach tailored to them as individuals (Durbeej, Alm, & Gumpert, 2014; Tew, Bennett, & Dixon, 2016).

Lastly, two participants indicated that redirecting impulses in socially acceptable ways could be helpful in reducing antisocial behaviour, with one suggesting that sublimating aggression into sculpting was effective and another implying that finding pro-social ways of *"getting their kicks"* was useful. This is supported by previous studies, in which the researchers argued for finding alternatives to meet the needs and motivations behind purposeful violent acts and that these alternatives might improve their problem-solving skills (Craig, Dixon, & Gannon, 2013).

All these factors concerning individuality lend support to the literature that suggests that idiographic approaches might be more effective. It may also be that this variety of approaches and the research that supports them, may give practitioners in the field more hope to carry out their work and, equally, more of an evidence based upon which to inform their practice. Thus, providing stability for the practitioner and possibly

positive outcomes, changing the perception of treatment for psychopathy.

In considering what could positively impact treatment outcomes, most of the participants also mentioned external factors, outside of therapy, which they felt impacted treatment outcomes. They observed that relationships outside of therapy with peers and romantic partners, children, employment and religion all aided rehabilitation. This notion has been supported by personality theory, which suggests that emotional stability can increase with environmental constructs such as marriage, family and community, all of which have an impact on identity (Roberts & Caspi, 2003 as seen in Roberts et. al, 2006).

More specifically, discussing psychopathy and romantic relationships, it appears that there has been some research in the area, most of which argues the complexities of building relationships when exhibiting traits and behaviours of psychopathy. This research has shown that psychopathy can lead to a decrease in the quality of interpersonal relationships. It has been argued that certain traits of psychopathy, such as lack of empathy, remorse and impulsivity, might result in poor relationships (Love & Holder, 2016; Cramer & Jowett, 2010; Jonason et al., 2012). Furthermore, those with psychopathy have been shown to typically have avoidant or anxious attachment styles, possibly stemming from trauma in their early years, which further complicates the establishment of interpersonal relationships (Li & Fung, 2014; Schiffrin, 2014). Despite these findings, it has also been shown that the higher the quality of romantic relationships, the higher wellbeing in those with psychopathy (Love & Holder, 2016). Although it might be difficult to establish or maintain, it does seem as though relationships do indeed serve as an important protective factors for those with psychopathy.

In terms of the impact of religion, faith has been recognised as an important factor in decreasing prison infractions. One study found that increased involvement in

religion was inversely correlated with violence within the prison (O'Connor & Perreyclear, 2002). Furthermore, a longitudinal study examining ex-prisoners upon release found that the greater the involvement in Bible studies, the less likely the ex-prisoners were to be arrested two and three years after release (Johnson, 2004). Thus, finding ways in which to *"facilitate"* relationships and possibly, a relationship with God, as some participants advocated may be crucial to improving client wellbeing and treatment outcomes. Moreover, this may prove particularly useful to those clients who struggle to engage in therapy, providing options to reach rehabilitation.

Lastly, in considering treatment approaches, two participants suggested that challenging their clients was unhelpful. For one, her client had created a fictitious account of his life, which has been shown to be quite common in psychopathy for the purposes of showing themselves in a positive light (Thornton & Blud, 2007). In this instance, challenging her client led to complete denial and seemed ineffective. In the second instance, challenging a client about violent threats made to the practitioner led to further threats. According to research, this could be because the individual had traits of grandiosity; thus the challenge could be perceived as a threat to his or her status (Hemphill and Hart, 2002; Hobson, Shine, & Roberts, 2000). Considering that challenging certain aspects of a client's story might be a useful way to avoid collusion and that it is often integral to certain treatment approaches, this may create issues in treatment. It may be that practitioners become apprehensive, holding back reflections and challenges and thus, inadequately delivering treatment. This apprehension may also impact the therapeutic relationship as the client may feel their hesitance.

Credibility

As discussed in the methodology chapter, qualitative researchers should aim to adhere to the three standards that Yardley (2000) established: 'Sensitivity to Context',

'Commitment, Rigour, Transparency and Coherence', and 'Impact and Importance'.

This researcher attempted to be sensitive to context. This meant that the philosophical underpinnings of the research method were understood. In adhering to this, the researcher took care to attempt to represent the subjective views of all the participants. For example, the participants had a diverse set of experiences across various settings and presentations, which meant that some had more first hand evidence to support their opinions. Despite this, all the participants' opinions were incorporated into the study and given the same level of importance in order to uphold subjectivity.

The researcher also recognised the importance of acknowledging the dynamics between the researcher and the participant. Yardley (2000) argues that creating an equal relationship between subject and researcher may be difficult and in this research it might have been ever more complex. More specifically, as a trainee psychologist interviewing fully qualified practitioners, this might have created a power imbalance because those who would usually be managers or supervisors were now the subjects. This might have resulted in an environment in which the participants were more willing to share experiences with someone less qualified and perhaps, less able to judge. However, it might also have resulted in the opposite, with the participants being less willing to show vulnerability to someone whom they would typically have authority over. To overcome this, the researcher attempted to be sensitive to this dynamic by promoting an environment in which their opinions and subjective experiences were accorded the highest importance, as evidenced by the participant information sheets.

The researcher also attempted to be sensitive to commitment, rigour, transparency and coherence (Yardley, 2000). In order to achieve commitment and rigour, the data in this study post analysis were reviewed a further three times. The transcripts and the tapes were also read and listened to twice after the initial analysis. This was done in recognition of the fact that, as a novice researcher and a full-time

professional doctoral student, the researcher may have missed certain nuances. This was also to ensure that the data was extensively engaged with and that the analysis was based on the closest representation of the participants' worlds as possible.

Furthermore, transparency and coherence was met by fully detailing the process of data collection and analysis in the methodology chapter. This chapter detailed, with Tables and Figures, what each process of the analysis looked like. As it was recognised that IPA was flexible and could, in part, be subjectively done, it seemed important to show clearly what steps were taken in the analysis. Moreover, in the findings chapter, the professional experience of the participants and the context of each quotation were described when relevant to provide a transparent, holistic view of the data.

Finally, the researcher seems to have fulfilled the criteria of impact and importance (Yardley, 2000) in that the findings support much of the current research on psychopathy today. This study also seems to add to the literature in a number of areas as discussed above. Within each theme, there were unique findings that might impact the field in important ways, possibly filling gaps in the literature.

Limitations and Future Directions

Despite the potential contribution of this study, there area a number of limitations that should be mentioned. Firstly, there appeared to be an issue around the gender of the participants' clients. This meaning that none of the clients had encountered females with psychopathy as they had worked primarily in men's facilities. It would have been helpful if the participants had had experience with females to recognise any similarities or differences between the genders. It may be that this could present itself as a limitation given that it does not consider differences between the genders.

Additionally, in terms of the dynamics of therapeutic relationships with

opposing or same genders, one participant said she felt a sexual dominance in the room which she thought could possibly relate to her gender and it may be interesting to further explore this idea with female practitioners. It could also be that some clients perceived their female therapists viewed their therapists as a mother type figure. Also, it may be that gender could have impacted the relationship with a male therapist and male client. For example, the therapist, similar to above, could depict a father figure or even a romantic partner. However, given the *"bravado"* as described by Priya, it may be that this masculinity and dominance could also impact the participants experience and it would be interesting to perhaps focus on these aspects in the future, creating a study which recognises the impact of gender on the therapeutic relationship in treating psychopathy.

Moreover, although the participants in this study had worked in a variety of settings, such as probation, forensic inpatient wards and prisons, none had worked extensively in one-to-one therapeutic work in specialist units such as Dangerous and Severe Personality Disorder (DSPD) units or high secure hospitals. This may have limited the participant's exposure to individuals who scored highly but also, to specific interventions which had been designed for those with psychopathy. For example, the most well-known programme for psychopathy is the Chromis Programme and none of the participants in this study had used this. However, it must be said that experience outside these specialist units may still provide an interesting perspective in that many of the participants likened psychopathy to the general and prison population, possibly suggesting that they saw those with psychopathy as no different than others.

It also appears as though a number of studies delving deeper into many of the themes found in this study may be useful. Firstly, a study investigating clients pride in the label of psychopathy would be useful. Understanding a client's motivation for be proud of this may help to ascertain their motivations, if any, and how best to approach

treatment. Secondly, as the therapeutic relationship is vital to therapeutic work, a study examining how best to build these relationships and also, how best to maintain them, even in the face of great difficulty may be important. Thirdly, considering the importance of relationships with peers and romantic partners may be favourable as these factors have shown to be fundamental to rehabilitation. Further to this, research into how religion may impact psychopathy could also appropriate.

Lastly, the participants did appear to represent a variety of disciplines. They included two forensic psychologists, one clinical psychologist, one counselling psychologist, and one psychoanalytic psychotherapist. However, it would have been interesting to try and recruit two from each discipline (as with the forensic psychologists) to possibly recognise differences within and between the disciplines. Additionally, it may be interesting for future research to analyse the difference ways in which professional from different disciplines approach psychopathy as this may help highlight a greater variety of approaches.

Relevance to Counselling Psychology

Counselling psychology is a unique discipline which, whilst recognising its novel approach to therapeutic work, is still able to blend into mainstream psychological services (Woolfe, Strawbridge, Douglas, & Dryden, 2010). Similarly, the participants appeared to acknowledge the same within their clients: that they were unique individuals with their own subjective viewpoints and experiences but that they could also be akin to one another with shared needs and backgrounds.

Participants promoted an individualised approach through two main means. The first was to acknowledge and appreciate the breadth of information given by the PCL-R which could indicate which traits and behaviours a particular client may have. The second was much less specific to psychopathy and spoke instead about specific needs,

motivations, and abilities of their clients. What brought these two areas together was the persistent idea that psychopathy was a diagnosis given to a profoundly heterogeneous population and they should be treated as thus. Fundamental to counselling psychology is this concept which seems to be both readily accepted and fundamentally vital to work with psychopathy (Woolfe, Strawbridge, Douglas, & Dryden, 2010; Cooper, 2008; Durbeej, Alm, & Gumpert, 2014; Tew, Bennett, & Dixon, 2016).

Moreover, many of the participants spoke out against the stigma associated with psychopathy and in doing so, fought the habit of individuals to reduce clients to just their diagnosis. In counselling psychology, this concept is often acted out in being cautious with diagnoses and how they are used (Woolfe, Strawbridge, Douglas, & Dryden, 2010). Diagnoses are often seen as a useful tool for informing practice, much like the participants used the PCL-R, but they do not provide an all-encompassing view of the client (Woolfe, Strawbridge, Douglas, & Dryden, 2010; Cooper, 2008). Additionally, counselling psychologists should recognise the possibility that clients could be victims of prejudice for this very reason (Woolfe, Strawbridge, Douglas, & Dryden, 2010).

An additional concept which presented itself during the interviews was the essential characteristic of compassion within the practitioner. As counselling psychology has a firm foundation in humanistic informed practices, compassion is an important aspect of the discipline's therapeutic work ((Woolfe, Strawbridge, Douglas, & Dryden, 2010). It is an integral part of practice to be able to value your client's subjective experience whilst upholding the essential principles of empathy and unconditional positive regard (Woolfe, Strawbridge, Douglas, & Dryden, 2010). Thus, the participant's belief in the power of compassion appears to be quite relevant to the field.

Conclusion

From the participants' accounts of their work with psychopathy, the area does truly seem to be quite uncertain. In terms of treatment methods, there seems to be a great deal of debate in the field as to what may work, if anything and this conflict was not missing from the participants experience. Many of them reflecting on the *"peaks and troughs"* of working with psychopathy and how, even though many of them could suggest general approaches that may be helpful, they largely felt pessimistic about treatments outcomes. This may indicate that a greater understanding of what level those with psychopathy can achieve in certain therapeutic outcomes may be vital, not only to the practitioner delivering the intervention but also, to the client.

It may also be that these interventions should be approached with a great deal of insight into the individual. Practitioners advocated for an informed approached, taking into consideration the individual PCL-R profiles and subjective lived experience. In this, it seemed as though practitioners tailored their approach to their clients, even in the face of great challenges.

Moreover, the difficulties encountered in treating psychopathy appeared to require a substantial level of reflection. The presentations associations with dangerousness and risk as well as the substantial difficulties in interpersonal relationships seemed to greatly impact the practitioners' ability to deliver therapy and build a therapeutic alliance. It may be that this area requires an even greater level of reflection and support, through supervision with managers and colleagues, than the traditional psychology environment. Additionally, the environment itself seems to be vital and efforts made to ensure it is containing and that it can maintain practitioner safety seems to be imperative.

Although the area may be uncertain, it is not without evidence-based suggestions for practice that may help current practitioners in the field. However,

further research as recommended in this thesis may help to close important gaps in the field, helping practitioner and client alike.

Reflexivity

My interest in personality first developed when I was doing my BA in Psychology. During this time, I was working with young children whom seemed to exhibit traits of neuroticism. It appeared that many of these children were experiencing difficulties at home and thus, struggled academically. It also seemed that, in some cases, they were largely overlooked and their difficulties were not being addressed. At the time, I was very aware that early intervention could be key to treating mental health difficulties. Therefore, I couldn't help but be concerned about the young children whom were going unnoticed. Thus, when I was accepted onto my MSc in Child Development programme, I wanted to take the opportunity to possibly highlight the importance of first recognising neurotic traits and secondly, addressing the underlying factors which may be influencing the presence of these traits. Although I was not able to find a correlation between the two, my fascination of this phenomena still remained.

Then, when considering my doctoral thesis, I wished to continue this research into the correlation between personality traits and mental health. As I was searching through the most up to date research in this area, I found myself veering into externalising disorders most likely from an interest in working with young people whom have committed crimes. Within this body of literature, I found psychopathy. The lack of research on the topic and the substantial amount of stigma surrounding it drew me in. As someone whom has dedicated much of my life to working with (and having compassion for) marginalised populations, I found this to be a fascinating area and decided to choose this as my topic of study.

Initially, I had hoped to interview those whom had been diagnosed with psychopathy as I wished to give voice to a population of people who seemed to have been completely drowned out. However, proving to the Ethics committee that the research would be safe to both myself and my participants appeared to be extremely

difficult and due to time constraints with completing my degree, I decided to switch to practitioners.

At first, this posed a number of issues. When I first began reading on psychopathy, I noticed that there was a level of therapeutic pessimism present in the field and that it was largely believed that psychopathy was not only untreatable but also, that those with the diagnosis seemed to be depicted as nothing more than violent criminals. My standpoint had been that, as a humanist, approaching this population with compassion could possibly lead to some progress in the area. However, my assumption at this point in time was that many practitioners held these biased views and that they themselves did not need their voices heard.

However, it wasn't long into my research when I spoke on the phone to several practitioners, originally asking to interview their clients that I found that the practitioners themselves had, in ways, been drowned out as well. Working with such a stigmatised population and also, within psychological services which are now often times overburdened, these practitioners also seemed to need a platform from which to share their stories. This was a turning point in my research where I was able to reassign the importance of my research and realise that practitioners too had a story to tell.

In attempting to honour these types of voices, I found great difficulty in compiling a literature review that fully represented the views of psychopathy. The most prominent difficulty in writing this chapter was to tolerate how overwhelming it could be to sit in what felt like a sea of predominantly pessimistic research. Although the research on treatment is lacking and largely inconclusive, research into the traits and behaviours of psychopathy as well as measurement tools is extensive. I found that, at times, I was being crushed under the weight of it and the responsibility of needing to choose which literature was most relevant. However, in discussing this issue with my colleagues, most of whom had experienced this as well, I realised that being selective

about the research stated was not a weakness and instead, a necessity. Thus, if research did not add new meaning to my literature review and impact the understanding of my research question, the study was not included in the literature review.

Vital to the process of writing this literature review was to find my own language to depict psychopathy and those whom have been diagnosed. As a researcher and practitioner who seeks to empower those who have had their voices drowned out, it was important for me to steer away from stigma and depict a multidimensional view of individuals. Given the terminology used in most literature such as "psychopath" or "psychopathic", I found myself almost cringing at the words. It was as though clients, patients and participants were being boiled down to their diagnosis, as if there was nothing that existed beyond this. Moreover, because of the heavy stigma associated with the label "psychopath", I found it inappropriate to ignore the long history behind the term (the belief that psychopathy was untreatable and that those with the diagnosis should be locked away) and to exercise caution when using it. Thus, I decided to use the phrasing "those with/diagnosed with psychopathy" and "those exhibiting traits and behaviours or psychopathy". After all, as a critical realist, I put subjective experience at the forefront of everything I did and I truly believed these individuals were so much more than just their diagnosis and it was important that my reader was able to recognise this.

When it came time to do my interviews, I had not expected the impact that different participants would have on me during interviews. The presentation of my participants and my reaction to them could not be predicted and I found that each initiated an entirely different response within me. For some participants, their insecurity in their therapeutic work was palpable, for others the hopelessness of the work was sewn throughout their interview and for some, their confidence in the field was sometimes intimidating and if anything, off putting. Although I had originally been

quite against the idea of an interview agenda as I did not want to steer my participants in any one direction, I found the interview schedule helpful in my attempts to remain consistent throughout my interviews. No matter the underlying feeling of their responses or even my reaction to their responses, I had an interview schedule to refer back to, ensuring that I was focusing on similar aspects of my participants work in each interview.

However, not all of my questions during the interview were based on the interview schedule as I was aiming to also be quite subjective, clarifying when I needed to (especially in the case of Akbar who had a very thick accent) and recognising the unique aspects of each interview. Although this is a method that is encouraged, I feel this may have allowed me too much flexibility that, in turn, exposed my anxiety. In some of my interviews, I found myself apologising for the nature of questions and even diminishing the validity of my questions. I believe this came about as a result of my own insecurities sitting in front of fully qualified professionals. I felt that, in a sense, I had no business being in a somewhat superior interviewer/researcher position. As someone with little experience in treating psychopathy, I felt very inferior to my participants and almost always, in awe of their experience. Despite reflecting on this in my reflective journal, I found it extremely difficult to resist the impulse to apologise for the questions asked and as a result, have had to keep this in mind for research in the future.

Also, in my first interview, I had difficulty in deflecting questions about my own experience with psychopathy. After this interview, I reflected on this and discussed methods to address this with a colleague. In subsequent interviews, I asked my participants if they had any questions for me prior to the interview. Anything concerning material that was already in the participant information sheet was answered and for anything that may influence their responses, I expressed to them that I would be

happy to answer their questions at the end of the research in order not to influence their interviews. This led to fruitful conversations after the interviews wherein participants asked me my motivations for studying this topic and why I found psychopathy so interesting.

In considering these discussions, I was pleasantly surprised by the impact that these conversations and the interviews had on my views of psychopathy. Although many of the interviews discussed in detail the challenges present in work with psychopathy, I was taken aback by the approaches that many said were helpful when working with psychopathy. Moreover, I was comforted by many of the participants wish to fight against the stigma associated with the diagnoses and moreover, their propensity to normalise their approach to psychopathy, saying that they would use much of the same tactics with their other clients. This perhaps felt somewhat humanising, blending psychopathy into the general population and stepping away from the othering of much of the research present in literature today. When hearing this, it was extremely difficult to resist the urge to agree with these viewpoints and even express how pleased I was to hear these observations. However, I knew that expressing this would be inappropriate and did my best to resist, not unlike working therapeutically and hearing similar viewpoints.

However, going into these interviews, I knew that I must bracket any prior assumptions or knowledge drawn from previous participants. Therefore, as I prepared for my interviews, I realised that each participant's story was unique and that they came from an equally unique individual. My participants all elicited starkly different reactions within myself, with each individual presenting new yet surprisingly similar views. Akbar for example seemed to be both hopeful and hopeless, through what seemed to be an unending process of reflection. His interview impacted me deeply, through his perseverance and dedication; he ignited my passion to continue on with my research.

During the interview, I found myself having to resist excitedly exclaiming, “Wow”, “Amazing” and any another statements of admiration. However, with Peter I felt much the opposite, as though I was being questioned for why I would choose such a cynical area and that ultimately, I was somehow naïve which was a feeling a grappled with after the interview. For this interview, I tried my best to keep going, to not break down and just give up trying to find some answers to my research question through what sometimes felt like an unending pessimism. Barry was particularly anxious and uncertain about psychopathy and the potential for violence. Yet, he appeared to want to fight against the stigma, even avoiding PCL-R assessments and diagnoses to do this. I found myself confused by his standpoint and perhaps as uncertain as he was. For him, I had to manage my own anxiety, brought on by his uncertainty, recognising what was mine and what was his. With Nina, it was quite the opposite, I felt her passion throughout the interview. She had such a depth of experience with psychopathy throughout her 20 years in mental health and she was able to articulate it and share it in such a vivid way. I found again that my own drive was pushed forward, as though she was confirming my curiosity and my right to speak out against stigma. Similar to Akbar, statements of admiration and amazement needed to be held back and I needed to resist the temptation of saying how fantastic she was for fighting this battle against stigma, much like I felt I was. Melanie was similar in her ability to speak out against the stigma but as an individual she seemed as though she doubted her own experience, perhaps because she had worked mainly in assessments. I felt humbled by her stories but also, completely fascinated with the depths of knowledge she shared concerning the gold standard of psychopathy assessments, the PCL-R. Again, similar to Akbar and Nina, I had to hold back my fascination. She had dealt with the assessment I dreamed of doing and unleashing this fervour, I felt, would do nothing but take away from my neutrality. Priya, not dissimilar to Akbar, placed heavy importance on reflection. With a

variety of experience throughout different services, her story waxed and waned with different emotions felt at every turn. Upon reflection, I realised that she had the most varied and diverse experience and for that I was grateful. As Priya was a counselling psychologist, I felt even more of a desire to speak up with admiration. Here level of reflection was so close to that of my training and I sat there trying to resist saying this.

My admiration for so many of them (and intimidation from Peter) may have not just come from my own passion in the area but also, the fact that I was sitting in front of fully qualified psychologists with far more experience than I had ever had. Moreover, they had extensive experience in an area that I dreamed of being a part of.

Additionally, I found that joining each interview together was the notion that psychopathy was profoundly difficult to treat. I suppose being dedicated to helping give those diagnosed a voice and identity outside of violence and callousness made this a particularly hard pill to swallow. I really had to focus here on the voices of these practitioners, most of whom were calling out for help and support with this difficult presentation. As a researcher, I had to accept that there were complexities, sometimes impossibilities, but that the world was not as simple as this and that these struggles did not need to lead to pure hopelessness. It was this reflection that kept me going with each interview.

But these reflections about each participant are not ideas which have only just occurred to me but rather, a culmination of what was written in my diary, shared in therapy, and taken to supervision. I was in constant reflection in the interviews and out. Within the interviews, I depended heavily on my interview schedule to ensure I was giving each participant a similar experience and being neutral by checking off the questions as I went. Outside of the interviews, the chaos I felt in my mind eventually became neatly contained reflections of who the participants were and how they made me feel, as depicted above. It was after each interview and before the next that I used

this reflection to compartmentalise and separate any assumptions I was bringing from the last.

But perhaps because of the admiration I had for my participants, I felt that this might have contributed to my difficulty in interpreting their stories. In the first steps of the analysis, I felt as though I was pushing my own agenda and thoughts onto that of the participant. Having come from doing quantitative research in my MSc, I could not process a method that did not involve numbers and SPSS. There was many times where I sat wondering why I could not just press a few buttons and have a data set. But despite this, I knew that quantitative had not resonated with me. To reduce people's experiences to numbers and the complexities of human emotions to clicks of a mouse seemed wrong to me. But regardless of my opinions of quantitative, I had thrown myself into the deep end of lived experience.

I had listened to the tapes and read through transcripts, making general notes on each transcript as each seemed to be completely unique in their tone and observations. I felt that I had tried my best to understand their subjective meanings, carefully reading through the transcripts, writing in my initial notes. However, I could not get out of my head the IPA studies that I had read and how out of touch with the data they seemed. I felt that many of them stretched the meaning and significance of the participant quotes and I was deeply afraid that I would do the same.

What added further complexity to this was the fact that many of the participant quotes overlapped between themes. At first, this felt like a near impossible feat to overcome and during the initial stage of analysis, I sat moving quotes from theme to theme and began to feel completely inexperienced and chaotic. However, as I read through each quote and theme, I realised that there were distinct features of each theme that could be applied. Thus, I gave a small synopsis of each theme in the Excel spreadsheet that I used to record each quote and this helped greatly in being able to

accurately place quotes in the appropriate themes. However, it was not until I reviewed the data for the first time, after my initial analysis that I was able to sit more confidently with my own interpretations. At that point, I realised that my initial interpretations were no different than my secondary ones.

Nonetheless, I still found that when writing the Findings chapter, this issue presented itself again. At first, as quite an anxious novice, I felt as though I was playing God, making my own interpretations of someone's live and experience. It felt uncomfortable, it felt wrong, and as a phenomenological practitioner who believes that her clients always no best, this seemed completely foreign. But after much reflection with colleagues and my supervisor, I realised that this type of issue may be quite normative and that being robust and flexible may be the answer to this. Thus, I allowed myself to sit with my participants' quotes, giving myself space and time to find what *may* be the meaning behind it, all whilst knowing that this truly was, just my interpretation.

However, despite the repeated review of the data, the fear that my research was merely a descriptive representation of my participants' accounts was one that I felt I could not shake. I read through my superordinate and subordinate themes and matched them to my participant quotes, during my panic this seemed to me to be merely descriptive. However, a meeting with my second supervisor wherein my table of themes and findings was reviewed helped to calm this anxiety. In reviewing my themes, my supervisor asked how many of the themes represented questions that I had asked the participants to which I responded only one. The first three themes arose out of a number of different questions and also, my participants own stories, sometimes initiated by their own thought processes. The only theme that came directly from a question was that of my research question; essentially, what works in the treatment of psychopathy? It was this checking in with other professionals that helped to reassure me. Upon reflection, I

knew that this was a factor which was present in my professional and academic career in that, often times, I needed reassurance from more experienced professionals to be sure I was on the right track.

Although the analysis itself had many complexities, I found that choosing theme labels came more naturally to me. I took pride in using the participant's actual words to label my themes. I found them refreshingly creative and true to the individual experience of my participants. But, however fun and natural it was, it did not come with its own unique challenges. As my participants all presented their own experiences, I needed to be mindful that I was ensuring I was representing all their views in these labels and not just a few. As a counselling psychologist, I tend to steer away from pathological language, looking instead for words and phrasing that add layers to individual experience. Moreover, as a critical realist, creativity was deeply important and thus, I felt the labels should represent my own creativity and ability to find a common thread between my participants. However, when choosing the name of Superordinate Theme 3, "An Area of "Uncertainty, Pessimism and Nihilism"" I was conscious that this language may be interpreted as particularly pathological. But, to me, these powerful words truly encompassed the dark and heavy hopelessness and uncertainty I felt in each interview. This idea of desperate therapeutic work being carried out with no end in sight, with no real guidance, with no real relationship, could not have been better articulated in any other phrase. It represented not only the pathologised history from which psychopathy had come but the course that was currently being painted by a lack of research and support for practitioners. It was my hope with this label that readers could feel the weight of these practitioners experience just as I had.

When writing the Discussion chapter, I had similar difficulties. I quite easily found research to support my findings and also, found that some of what my

participants had discussed was unique. But the most challenging aspect of this was adding interpretation to the discussion and trying to suggest what meaning certain aspects of the interviews may have. I felt again as if I was pushing my own agenda onto the data but forced myself to specifically link the data and the current research, in an attempt to make the interpretations more objective.

As I was coming toward the end stages of thesis, I made the decision to explore any new literature that had come out since 2016, when I first began this process. After looking at Ebsco Host, I entered a few relevant terms into a Google search. Right away, my eyes were drawn to a news article claiming that psychopathy was untreatable. I read through the article confused and enraged, everything in the article was out-dated and littered with unhelpful myths. In this moment, I was struck by the hopelessness my participants had shared but perhaps, in a different way: I felt at that moment that despite all the research disproving these myths, people still believed them and what was more is that, people were still publishing material that promoted them. It felt as though my research would not matter because psychopathy's fate had already been sealed since Cleckley's (1941) impression of the diagnosis first came about. There was a level of acceptance that had to come with this: accepting that I could not change all these opinions and accepting that my doctoral thesis may not be able to change the opinions of even a few. It was then that I knew that I could send an email of concern to the journalist, I could speak openly to people in the community about psychopathy, but I could not entirely change an opinion that has been ingrained in society for 70 years.

Over the past year, this research and my own reflections have filled me with such an array of emotions that I dare say no one can describe this experience. But if I could sum it up in just a few it would be that I have gained immense respect for practitioners in the field of psychopathy, who in the face of not only stigma but also, an immensely complicated presentation, continue to work with their clients and colleagues

a like. It would also be that, although persistent and unhelpful beliefs around psychopathy exist, I make no claims that I may be able to adequately change any of them but my decision to continue to conduct research in this field may have just one thing that maybe psychopathy needs a bit more of: hope.

My hope, however small, has come from one study I found just as I began researching psychopathy. It said that in 1974, Michael Scriven, a member of the American Psychological Association (APA) approached the ethics committee and proposed that all clinical members should "be required to present a card to prospective clients" explaining "that the procedure they were about to undergo had never been proven superior to a placebo" (Smith & Glass, 1977). At that time, many academics were heavily influenced by Eysenck's (1952, 1965) earlier claims that 75% of neurotics recovered without treatment and his subsequent conclusion that psychotherapy was ineffective. However, just three years later, Smith and Glass (1977), in a meta-analysis of 400 studies, showed that those who were treated with psychotherapy or counselling were better off than 75% of their untreated counterparts. It is historical events like this that help me to maintain the belief opinions can be changed, however slowly.

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Appendix A

Research Participation Information Sheet

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)

Erin Vignali
Contact Details: u1516966@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Counselling Psychology at the University of East London.

Project Title

Practitioners experience of working with those who have psychopathy: An insider's perspective

Project Description

This research aims to look at how practitioner perspectives of working with psychopathy.

As part of the research you will be invited to an interview to discuss your past personal experience of you work with psychopathy. This project aims to give you an opportunity to share your experience with me and to help professionals and policy makers to inform their decisions based on your perspective.

As a result of participation in this study, you may feel distressed speaking about a difficult time in your professional life. You are advised to contact your service or line manager if you become distressed after the interview. Alternatively, you can contact any services enclosed with this form. The researcher will also stop the interview if you feel distressed and do not wish to continue with the interview at any point.

Confidentiality of the Data

The interviews will be will be audio recorded with a Dictaphone and transcribed after the interview is complete. Your identity will be protected, as the data will be

anonymised in the research itself. All transcriptions will be saved on a password protected file on my personal computer. Research supervisors at the university and examiners may have access to listen to the original audio recordings however they will uphold confidentiality as well.
Data will be kept after submission of research for five years, for publication purposes in the future. Any identifiable information will be changed to protect your identity.

Location

Interviews will be conducted in an allocated room at the X service.
The interviews will be approximately one hour. Before the interview begins, you will have a chance to share any concerns and ask any questions you may have. If any concerns or questions arise during the interview, I will allot time at the end of the interview to discuss these.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time before or during the interview. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. You will have a right to withdraw up until X date.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr. Zetta Kougiali, School of Psychology, University of East London, Water Lane, London E15 4LZ, 020 8223 4497, Z.Kougiali@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk)

Thank you in anticipation.
Yours sincerely,
Erin Vignali

Appendix B

Invitation Email & Consent Form

Re: Psychopathy Research

Erin Marie VIGNALI

Mon 19/03/2018 17:58

To: ;

Erin Vignali - Research Participant Information.docx;

Dear ,

Thank you very much for your prompt response. Tomorrow I should be home and ready for interview at . Therefore, I would like to formally invite you for an interview you on **at** .

Attached is your invitation letter as well as the consent forms. Please note that the consent form will need to be signed before the interview can take place.

I look forward to receiving your consent form and interviewing you tomorrow. Thank you very much for taking the time to be part of my research.

Kind regards,

Erin Vignali

Appendix C

Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Individuals who have been sentenced and diagnosed with psychopathy: An insider's perspective of psychological treatment

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. I understand that confidentiality may be breached if I express suicidal intent.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time prior to the interview without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw 2 weeks after the interview, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………..

Participant's Signature

……………………………………………………………………………………...

Researcher's Name (BLOCK CAPITALS)

……………………………………………………………………………………...

Researcher’s Signature

……………………………………………………………………………………………

Date: ………………………..……..

Appendix D

Debriefing Letter

UNIVERSITY OF EAST LONDON

Debriefing Letter

Thank you for participating as a research participant in the present study concerning your experience in therapy for psychopathy. The research aims to examine your experiences in order to give you a voice and best inform future practice.

Again, we thank you for your participation in this study. If you know of any friends or acquaintances that are eligible to participate in this study, we request that you not discuss it with them until after they have had the opportunity to participate. Each interview will be participant-led and any information given to these participants may affect their story.

If you have any questions regarding this study, please feel free to ask the researcher at this time or email either myself or my research supervisor at the contact information below:

Erin Vignali: u1516966@uel.ac.uk
Dr. Zetta Kougiali: School of Psychology, University of East London, Water Lane, London E15 4LZ, 020 8223 4497, Z.Kougiali@uel.ac.uk

In the event that you feel psychologically distressed by participation in this study, we encourage you to use any of the resources below or contact X member of staff.

Thank you again for participating and sharing your story!

If you need urgent help:

- **Contact the Samaritans**
  Call for free: 116 123 (24 hours a day)
  Text: 07725 90 90 90

London and national contacts:

- **Health Information Service** (provides information on NHS services)
  Call: 0800 66 55 44

- **NHS Direct**
  Call: 0845 4647

Please note that some calls my cost. Numbers beginning with 0800 and 0808 are free to call from landlines and mobiles. Numbers beginning with 0300 are local rate.

Appendix E

Thank You Email & Debriefing Letter

Erin Vignali - Research Participant Information.docx

Erin Marie VIGNALI

Fri 23/02/2018 15:11

To: [redacted] >;

Erin Vignali - Research Participant Information.docx; ATT00001.htm;

Dear [redacted]

Thank you again for participating in my research study. I greatly appreciate the time you've taken and the insight provided. Attached are the participant documents including the invitation letter, consent form and debrief letter.

Thank you again for your time!

Kind regards,

Appendix F

Initial Psychopathy Research Email

Psychopathy Research

Erin Marie VIGNALI

Mon 12/03/2018 15:08

To: >;

1 attachments (172 KB)

Erin Vignali - Research Advertisement.pdf;

Dear ,

My name is Erin Vignali and I am a trainee counselling psychologist at the University of East London. I am in my final year and doing research for my doctoral thesis on psychopathy. I was wondering if you, your colleagues, or anyone you know may be interested in being interviewed about their work with psychopathy.

I am aiming to interview non-NHS and non-HMP practitioners from all psychological disciplines about their therapeutic work with psychopathy. My focus is to give voice to practitioners to share their experience. If you think there may be practitioners at the university that would be willing to be interviewed, please let me know.

I would like to mention that I only have the approval of my university ethics committee at the moment.

You can contact me via this email address or call me on .

Kind regards,

Erin Vignali

Appendix G

Research Advertisement

TREATMENT FOR PSYCHOPATHY

AN INSIDER'S PERSPECTIVE

Participants Needed

My name is Erin Vignali and I am conducting research on psychopathy and treatment as part of my Doctorate in Counselling Psychology.

My research aim is to give voice to those practitioners whom have worked with individuals whom have been diagnosed with psychopathy. My project strives to be a collaborative initiative which showcases your practice in aid of academia and policy.

University of East London

If you are interested in participating in this research, please contact me at the information below. Interviews can be conducted in person, Skype or on the phone.

u1516966@uel.ac.uk

Appendix H

Interview Schedule

1. Ask some information about the background; ie: where they worked, for how long, how many patients with psychopathy did they see, what gender, forensic or non forensic.
2. Can you tell me about your experience working with individuals who have been diagnosed with psychopathy?
3. Thinking back to working with this population, were there any differences or similarities that you noticed?
4. What factors did you feel contributed to the outcome of the therapy?
5. What factors did you feel contributed to the therapeutic relationship?
6. How did you feel about the nature of the therapeutic relationship? For example, could you say whether or not it was a strong or weak relationship?
7. Do you think that there was something particularly useful?
8. Or not?
9. What would you add?
10. In your opinion, what do you think works best for this population?
11. Given your experience, how do you feel about treatment for psychopathy in general?

Appendix I

Transcript Analysis Example (Barry (1))

Initial Note	Emerging Themes		Participant Response
Psychopathy as similar to forensic populations Psychopathy as violent and damaged	*Already implying no difference without having asked similarity or difference* *Damaged/violent/sexual violence equating with psychopathy* *Possibly equating with forensic population in general?*	P:	Umm well if I go back to the probation hostel, um, I am not sure quite how much it was different working with the individuals who scored, you know who were classed as having the diagnosis of psychopathy versus those who didn't, um, because everyone there was quite damaged or quite violent or had a really significant history of the violence or sexual violence.
		I:	**Yes.**
Psychopathy as violent/to be concerned about	*Worry around those with psychopathy* *Again an equate with violence* *Frightening to be around*	P:	I really only remember one person who was a young man, very, um, sort of muscly, who was like he was very worrying, the probation were very worried about him because he scored very highly in psychopathy and, um, he was quite frightening actually. It was not nice being around him because, uh, of this undercurrent of violence. And in fact, um, he at one stage he sort of basically kicked in his door and kicked even the door surrounds and kicked the door off the wall.
		I:	**Mmm.**
Fear created by label itself Scorers have status Uncertainty for root of brag	*Psychopathy has a status in prison* *Prison environment as containing and safe for practitioner and patient alike* *A kind of bragging about crimes* *For Barry, possible fear of the unknown, not*	P:	And I was working that evening so had to deal with it and it was quite frightening. I think at that point I was quite frightened, um, about psychopathy and not knowing much about it. Um… and then in the prison it was fine, we have just had some people in the groups. It was fine in the

	knowing about psychopathy *Uncertainty as to why patient talked about it in such a manner – perhaps bragging, perhaps to garner respect but no mention of other possibilities?*		groups and I think they were quite contained in the prison, um, and I think they had quite a high status amongst most of the prisoners. And we had one chap who came into our group talking about how he had been cutting up someone in a bar, um, and it was quite strange to hear but he didn't feel worrying in terms of my own personal safety because I think the guy felt very contained and he was talking about it in a way, you know that, I think he enjoyed the fact that people kind of respect him or not respected but looked up to him. I'm not quite sure exactly why he was talking about it.

Appendix J

Excel Spreadsheet Example (Themes & Line Numbers)

Superordinate Theme	Subordinate Theme	Barry (1)	Melanie (2)	Peter (3)	Priya (4)	Nina (5)
Powerful Label (Yellow)	"Damning Label": Negative reactions to the general label of psychopathy without considering factors or scores	1.27-1.29, 1.45-1.49, 1.51-1.52,1.219-1.220, 1.222-1.227, 1.387-1.394		3.156-3.160	4.152-4.158, 4.317-4.334, 4.339-4.342	5.34-5.41, 5.182-5.189, 5.452-5.457
	"Badge of Honour": Reaction to the label as being positive or giving status	1.54-1.60	2.112-2.124		4.335-4.337	5.54-5.77, 5.82-5.94
	To Label or to Not?: Act of not doing the assessment or assigning traits to someone who has not bee assessed	1.155-1.161, 1.163-1.166, 1.175-1.178, 1.180-1.183, 1.185-1.192			4.421-4.424	5.42-5.50,5.384-5.389, 5.367-5.375, 5.448-5.452

Appendix K

Ethics Application Form

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

*Students doing a Professional Doctorate in Occupational & Organisational Psychology and PhD candidates should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to: http://www.uel.ac.uk/gradschool/ethics/

If you need to apply to have ethical clearance from another Research Ethics Committee (e.g. NRES, HRA through IRIS) you DO NOT need to apply to the School of Psychology for ethical clearance also.
Please see details on www.uel.ac.uk/gradschool/ethics/external-committees.
Among other things this site will tell you about UEL sponsorship
Note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised.

Before completing this application please familiarise yourself with:

The *Code of Human Research Ethics (2014)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf

And please also see the UEL Code of Practice for Research Ethics (2015)

http://www.uel.ac.uk/gradschool/ethics/

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.

2. Type your name in the 'student's signature' section (5.1).

3. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc** (See page 2)

4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identity its content. Your supervisor will then look over your application.

5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

6. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants (see 23 below)

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external organisation if you need it (e.g. a charity or school or employer etc.). Permissions must be attached to this application but your ethics application can be submitted to

the School of Psychology before ethical approval is obtained from another organisation if separate ethical clearance from another organisation is required (see Section 4).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. This is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

  If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Mary Spiller (Chair of the School Research Ethics Committee) at m.j.spiller@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another in order to conduct research with vulnerable populations.

Your details

1. **Your name**:

Erin Marie Vignali

2. **Your supervisor's name**:

Zetta Kougiali

3. **Title of your programme**: (e.g. BSc Psychology)

Professional Doctorate in Counselling Psychology

4. **Title of your proposed research**: (This can be a working title)

Treatment for Psychopathy: An Insider's Perspective

5. **Submission date for your BSc/MSc/MA research:**
   31 August, 2018

6. **Please tick if your application includes a copy of a DBS certificate** ✓

7. **Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons (Chair of the School Research Ethics Committee) (m.j.spiller@uel.ac.uk)** ☐

8. **Please tick to confirm that you have read and understood the British Psychological Society's Code of Human Research Ethics (2014) and the UEL Code of Practice for Research Ethics** (See links on page 1) ☐

2. About the research

9. **The aim(s) of your research:**

To gain insight of the treatment of psychopathy through the experience of the practitioners whom treat psychopathy.

10. **Likely duration of the data collection from intended starting to finishing date:**

Unknown

Methods

11. **Design of the research:**
(Type of design, variables etc. If the research is qualitative what approach will be used?)

Interpretative Phenomenological Analysis (IPA) of semi-structured interviews detailing the participant's past experience treating psychopathy.

12. **The sample/participants:**
(Proposed number of participants, method of recruitment, specific characteristics of the sample such as age range, gender and ethnicity - whatever is relevant to your research)

I will aim for ten participants of any age range, gender and ethnicity who have been worked to treat psychopathy.

Participants will be recruited through, charities, and organisations (list attached to this application) with an advert detailing my research and requesting participants (advert attached to this application). I will also be recruiting through social media (ie: posting on the BPS website as well as contacting mental health groups to post on their websites/forums). These organisations will cover mental health, personality disorders, antisocial personality disorder, and ex-offender support.

I will send a letter to the relevant organisations briefly explaining my research and requesting that they display an advert as an expression of interest for potential

participants. Services will also be requested to suggest potential participants that might be willing to be interviewed. I will also be asking the service for permission to interview their staff. To date, I have made contact with several private psychiatric hospitals and made contact with university students in the field of forensic psychology in order to ask permission to circulate a flyer once I receive ethics approval.

13. Measures, materials or equipment:
(Give details about what will be used during the course of the research. For example, equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application)

For this study, the interview will be participant-led but will aim to cover practitioners experience in treating psychopathy. There is much research to support the claim that psychopathy is difficult to treat. The interview will surround the topics of: what the practitioner felt worked in therapy, didn't work in therapy, as well as relational factors such as the therapeutic relationship.

14. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

Yes

15. Outline the data collection procedure involved in your research:
(Describe what will be involved in data collection. For example, what will participants be asked to do, where, and for how long?)

Participants will be asked to participate in semi-structure interviews wherein they will be asked open-ended questions detailing their experience treating psychopathy. The interviews will be one hour or more dependent on the questions above being answered. If the participants are recruited through a charity, I will request that they could facilitate the interview by allowing me to conduct it in a room in their premises. The interview will be scheduled at a time which is convenient for both myself and the participant. Interviews may also be conducted over the phone or Skype to accommodate for those participants whom are outside of London or who have limited time.

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed:

16. Fully informing participants about the research (and parents/guardians if necessary): Would the participant information letter be written in a style appropriate for children and young people, if necessary?

Participants will be informed that the aim of the research is to investigate their

experience treating psychopathy.

17. Obtaining fully informed consent from participants (and from parents/guardians if necessary): Would the consent form be written in a style appropriate for children and young people, if necessary? Do you need a consent form for both young people and their parents/guardians?

Informed consent will be gained before interviews take place which details the nature of the research and the interview process, the procedure to be carried out with their transcripts, and that they may withdraw from the study up to one month after data collection. A specific date, time and location will be provided on their Invitation to Participate and Consent Forms. Informed consent will be read to them prior to the interview beginning. This form will also include my promise to uphold confidentiality.

18. Engaging in deception, if relevant:
(What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.)

I will not be engaging in any deception. My participants will know the details of my study.

19. Right of withdrawal:
(In this section, and in your participant invitation letter, make it clear to participants that 'withdrawal' will involve deciding not to participate in your research and the opportunity to have the data they have supplied destroyed on request. This can be up to a specified time, i.e. not after you have begun your analysis. Speak to your supervisor if necessary.)

In my invitation letter, participants will be told that they have the right to withdraw up to one month after data collection. Participants will be informed that withdrawal would include that all their data will be destroyed. Participants will also have the right to withdraw from the interview at any point during the interview itself.

20. Anonymity & confidentiality: (Please answer the following questions)

20.1. Will the data be gathered anonymously?
(i.e. this is where you will not know the names and contact details of your participants? In qualitative research, data is usually not collected anonymously because you will know the names and contact details of your participants)
NO

21. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?
(How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually names and contact details will be destroyed after data collection but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? Make this clear in this section and in your participant invitation letter also.)

Participants and any other people mentioned in the interview will be referred to by pseudonyms in any written work. Any names of the establishments where they worked or organisations they belong to will be changed in any written work. Any other names of facilities which they could be identified through will be changed. This will be included on the Invitation Letter as well as the Informed Consent. All

information will be kept on my computer. My computer is password protected and the file where the information is kept will be password protected. The original transcripts and data will be destroyed after five years, in accordance with the British Psychological Society.

22. Protection of participants:
(Are there any potential hazards to participants or any risk of accident of injury to them? What is the nature of these hazards or risks? How will the safety and well-being of participants be ensured? What contact details of an appropriate support organisation or agency will be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?)

N.B: If you have serious concerns about the safety of a participant, or others, during the course of your research see your supervisor before breaching confidentiality.

As the material covered will be quite sensitive, there may be some distress experienced by the participants. If participants do become distressed, they will be advised to speak to their service/line manager. The debriefing letter will include a list of resources (charities, counselling lines, etc.; list attached to this application) where the participants can turn to if distressed. Additionally, should the participant feel uncomfortable, they will be advised that they can stop the interview at any time without any judgement or consequence.

23. Protection of the researcher:
(Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you? If interviewing participants in their homes will a third party be told of place and time and when you have left a participant's house?

As mentioned above, the material covered might be sensitive and may include details of they participants' work that may be upsetting. This material may have an impact on my own well-being. In order to manage this distress, I will reflect on these matters in personal therapy. If I need immediate support after the interview, I can also call the Samaritans line in order to best manage my feelings. Additionally, I will be attending debriefing meetings with my research supervisor who is an experienced forensic psychologist.

Also, I will familiarise myself with the organisation's healthy, safety and security as mentioned above.

24. Debriefing participants:
(Will participants be informed about the true nature of the research if they are not told beforehand? Will participants be given time at the end of the data collection task to ask you questions or raise concerns? Will they be re-assured about what will happen to their data? Please attach to this application your debrief sheet thanking participants for their participation, reminding them about what will happen to their data, and that includes the name and contact details of an appropriate support organisation for participants to contact should they experience any distress or concern as a result of participating in your research.)

Participants will be fully informed about the nature of the study before the interview begins. They will know that the study aims to find their own individual experience treating psychopathy, free of any judgements or assumptions about their experience or them as a person. They will be reminded that all their data will be kept password protected on my personal computer and that they have the right to withdraw up until the stage of analysis. I will ask them to share any concerns that they may have before the interview and that they will also be given time at the end of the interview should any new concerns arise.

25. Will participants be paid? NO

If YES how much will participants be paid and in what form (e.g. cash or vouchers?)
Why is payment being made and why this amount?

Participants will not be paid.

26. Other:
(Is there anything else the reviewer of this application needs to know to make a properly informed assessment?)

4. Other permissions and ethical clearances

27. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?

Yes

I will be in contact with known staff members in the charity from which I will be recruiting participants. I will seek their permission to advertise my research.

If your project involves children at a school(s) or participants who are accessed through a charity or another organisation, you must obtain, and attach, the written permission of that institution or charity or organisation. Should you wish to observe people at their place of work, you will need to seek the permission of their employer. If you wish to have colleagues at your place of employment as participants you must also obtain, and attach, permission from the employer.

If YES please give the name and address of the institution/organisation:

Please attach a copy of the permission. A copy of an email from the institution/organisation is acceptable.

Please note that initial contact has been made to the organisations included in Appendix 1 as well as practitioners who have collaborated with UEL (BSc Forensic Psychology). Upon receipt of permission and before data collection the permission will be sent to the reviewer for approval.

In some cases you may be required to have formal ethical clearance from another institution or organisation.

28. Is ethical clearance required from any other ethics committee?

YES / NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? YES / NO

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation is acceptable.

PLEASE NOTE: Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committees as may be necessary.

29. Will your research involve working with children or vulnerable adults?*
YES

If YES have you obtained and attached a DBS certificate? YES

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

N/A

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see www.uel.ac.uk/gradschool/ethics/involving-children/

30. Will you be collecting data overseas?
NO

This includes collecting data/conducting fieldwork while you are away from

the UK on holiday or visiting your home country.

* If YES in what country or countries will you be collecting data?

Please note that ALL students wanting to collect data while overseas (even when going home or away on holiday) MUST have their travel approved by the Pro-Vice Chancellor International (not the School of Psychology) BEFORE travelling overseas.

http://www.uel.ac.uk/gradschool/ethics/fieldwork/

IN MANY CASES WHERE STUDENTS ARE WANTING TO COLLECT DATA OTHER THAN IN THE UK (EVEN IF LIVING ABROAD), USING ONLINE SURVEYS AND DOING INTERVIEWS VIA SKYPE, FOR EXAMPLE, WOULD COUNTER THE NEED TO HAVE PERMISSION TO TRAVEL

5. Signatures

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Erin Vignali

Student's number: u1516966 Date:

Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor's name: Zetta Kougiali Date:

Attached are copies of:

1. **PARTICIPANT INVITATION LETTER(S)**
2. **CONSENT FORM(S)**
3. **PARTICIPANT DEBRIEF SHEET**
4. **SCANNED COPY OF CURRENT DBS CERTIFICATE**

Appendix L

Ethics Decision Letter

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION **For research involving human participants** BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Laura McGrath

SUPERVISOR: Zetta Kougiali

STUDENT: Erin Marie Vignali

Course: Professional Doctorate in Counselling Psychology

Title of proposed study: Treatment for Psychopathy: A Practitioners' Perspective

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

Approved

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name *(Typed name to act as signature):* Student number: Date: *(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

MEDIUM (Please approve but with appropriate recommendations)

LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Laura McGrath

Date: 01/03/2018

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard